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Tuesday 10 September 2002

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Mardi 10 septembre 2002

Standing committee on estimates

Ministry of Health and
Long-Term Care

Comité permanent des budgets des dépenses

Ministère de la Santé et
des Soins de longue durée

Chair: Gerard Kennedy
Clerk: Susan Sourial

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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON ESTIMATES

COMITÉ PERMANENT DES BUDGETS DES DÉPENSES

Tuesday 10 September 2002

Mardi 10 septembre 2002

The committee met at 0920 in room 151.

MINISTRY OF HEALTH AND LONG-TERM CARE

The Chair (Mr Gerard Kennedy): Minister, welcome. Some sympathy for the reason for your delay, given that the traffic also affected me this morning. But we will commence, with your attendance. I'll start by introducing people, welcoming them to the estimates committee. Our job here is seven and a half hours of examination of the Ministry of Health. I'd like you to know that we are assisted here by an able staff. We have clerking here today Katch Koch, assisted by Tonia Grannum from the clerks' office, Tim Humphries from Hansard, and Anne Marzalik is the researcher for the committee.

I want to welcome all the members here today. Everyone is aware of how we proceed. Minister, you have half an hour to indicate to us whatever remarks you'd like to put, followed by half an hour for each of the parties. I'd also like to welcome your staff here, Minister. I'll note, for posterity, I suppose, that this is the strongest showing of support we've had for any minister. I note for the record that they are all Ministry of Health employees, but we're glad to have some 48 experts here. I'm sure it will enhance the job of this committee today, which is a serious obligation, to examine the expenditures and other operations of the largest ministry of the government. With no further ado, Minister?

Hon Tony Clement (Minister of Health and Long-Term Care): Thank you very much for the opportunity, Chair, and thank you for the indulgence of the committee. Now that I'm no longer transportation minister, I can blame traffic now and again. Thank you, as I say, for your indulgence. I will also ask for your indulgence around lunchtime. I have a commitment that might take me about a half an hour beyond your scheduled return, but I'm sure staff would be happy to carry on until I can extricate myself from that commitment as soon as possible.

I'm joined at the front by some members of the able staff to which you referred. I am flanked by deputies. Deputy Minister Phil Hassen is on my right, and on my left is associate deputy minister Colin Andersen. Assistant deputy minister Maureen Adamson is also with us. Since Ben Hur, the play, is not on today, we do have the cast of Ben Hur behind me. I'm sure they'll be able to ensure that I am as accurate and as comprehensive as possible, which is certainly part of my obligation which I take seriously.

This is the review of the estimates for the Ministry of Health and Long-Term Care for the year 2002-03. This is also an opportunity to discuss the government's and my ministry's achievements with respect to Ontario's health system as they are applied through our budget. I am pleased to outline our plans to continue with the creation of a health system that works for all Ontarians.

Our government, the Ernie Eves government, knows that Ontarians, indeed all Canadians, see universally accessible health care as central to our way of life. I was reminded of this fact recently at the health ministers' meeting in Alberta just last week.

Since 1995, our government has been working hard to modernize Ontario's health system so that it can keep pace with our changing times and needs. We want to make sure that it serves people now and in the decades to come. Our efforts have been led by what I would call an unwavering commitment to the underlying principles and the foundations of the Canada Health Act, which, among other things, embrace the principle of universal access to our country's and our province's publicly funded health system.

The health system we've built has established a strong foundation for the future. However, as you probably are aware, with levels of federal funding for health care still below what they were during the Mulroney years, we are all forced to come up with creative solutions to make the best use of our fixed resources that seem to be sometimes shrinking compared to the costs we face.

This pressure to find solutions has motivated a number of exercises in health care sustainability over the past year. We've seen this on the national scene with the Romanow commission, the Kirby committee, and Alberta's Mazankowski report, just to name a few. While such discussion of course is healthy, it should not stand in the way of action. To address the complexity of health care issues and delivery systems across Canada meaningfully, we need broad-minded and national debate. But this debate should not become an excuse to delay federal commitments to our publicly funded health care system.

In the absence of federal involvement, I can tell you that provincial and territorial leaders have been forced to look for solutions on their own. Here's how we did it in

Ontario. We engaged the people we serve in a dialogue on health care. We asked what we could do better and what the people of Ontario wanted changed. We thought it made sense to ask the people who the system was designed to serve, who pay for the system through their taxes, what shape they wanted it to take in the coming years. Every Ontario household was given the health care questionnaire to complete. More than four million questionnaires went out, to every household across the province, and more than 400,000 were returned to us. Anyone who knows anything about marketing knows that a 2% or 3% return on direct mail is usually exciting for the marketers. We had a return of 10%. That tells you the commitment Ontarians have to a better-functioning health care system.

We had expert tabulators consider the returns—I had the opportunity to read hundreds of those responses myself—and here is what we found. Although people raised many specific issues, most system-wide concerns stemmed largely from the shortage of medical staff or the long waits to get a procedure or a test done.

After we tabulated all the results, I'd like to loosely summarize the feedback we got. People said: "Make sure I have access to the health care system when I need it." "Make sure it's funded adequately." "Make sure it's working well." "When I'm sick ... I want to see a professional, I want them to have the tools to diagnose and to treat me, I want it to happen as fast as possible, and ... I'd rather not get sick at all."

Put more formally, the people of Ontario gave us seven priorities for improvement. They had three system priorities: first, that our health system must be universal and easily accessible; second, that our health system must remain a priority for future levels of public funding; third, that our health system must be managed with excellence for both consumers of the health system and for performance accountability. And they had four service priorities: increase the number of doctors and nurses in the system; provide improved access to early diagnostic tools to catch illnesses earlier; reduce waiting lists; and refocus the health care system to help keep people well in the first place.

That's what the people of Ontario told us, and we're listening. That consultation and the necessary response to it have helped shape our focus over the past year and they continue to do so with this year's budget. That budget, I can report to you, this year is $25.5 billion. This represents an increase of 7.3% over last year. Indeed, since this government first came to power in 1995, that represents an increase of 45% or nearly $8 billion.

This growth has supported a number of initiatives in our priority areas, and I'd like to address the priority areas in the remaining time I have today.

First, health human resources: in terms of health human resources, we remain committed to responding to the needs of Ontario's communities, and indeed this has been a central priority. We recognize that having adequate physician services throughout the province is essential for Ontario to meet its current and future health care needs. Given the persistent problem of physician distribution in Ontario, with shortages in some geographic areas or population groups, we have moved forward on several initiatives to improve access to physician services throughout the province. These are a direct response to the recommendations contained in the report of the Expert Panel on Health Professional Human Resources, which was released in early 2001.

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So we are moving forward with plans to establish the new two-site medical school, with campuses in both Sudbury and Thunder Bay, to encourage physicians to learn and live in northern Ontario. We're also providing up to $40,000 in tuition reimbursement and location incentives for each medical student to practise in underserviced locations upon graduation.

We've added all of the 160 new medical school positions announced last year. Forty-seven positions were added just this fall, completing a 30% overall increase in the number of medical school positions in the last three years. We've also created 50 additional rural, regional and northern post-graduate training positions. These positions are in enhanced family medicine and core specialties such as anaesthesiology, general surgery, obstetrics and gynecology.

We're also working with the University of Western Ontario and McMaster University to implement two new rural and regional training networks in southwestern Ontario and central south Ontario respectively.

Last year, we announced a three-year, $20-million investment to help retain doctors in northern Ontario. This provided eligible physicians with a $7,000 retention initiative paid at the end of each year over a three-year period.

Since 1999, we've more than tripled opportunities, from 24 to 90, for international medical graduates—as we call them, IMGs—to get the training and assessment they need to practise medicine in Ontario. This includes a new program with opportunities for up to 40 foreign-trained physicians to enter a fast-track program of assessment and registration in return for practising in an undersupplied community. I'm pleased to report that the first assessments began in May. We hope some of these doctors will begin practising by the end of this year.

In addition, we're undertaking a comprehensive review of the underserviced area program and enhancing our capacity within the ministry for health workforce planning.

Of course, we recognize the vital role nurses play in Ontario's health care system and the need to continue to build on nursing investments. To this end, we've made several new announcements to address nursing issues in Ontario. These include a commitment to more than double the number of nurse practitioners in the province, a commitment to make the changes necessary to allow all nurses to work at full scope of practice, and $100 million for the long-term-care facilities sector to enhance the delivery of nursing and personal care. This should add up

to 2,400 nurses and personal care workers to facilities across this province.

Since 1999, we've invested more than $800 million to create new full-time and part-time nursing positions in Ontario. We continue to work with our nursing stakeholders, the employers in the province, and the nursing researchers to support the profession.

Fundamental to our vision for the future of our health care system is primary care reform and expansion: the development of an accessible, integrated, dependable system where physicians and other practitioners work in teams to provide comprehensive care to patients 24 hours a day, seven days a week.

I'm proud to report that we've added five new family health networks since the spring, one in each of Oakville, Guelph, Campbellford, Mount Forest and Stratford. These new networks join 14 existing networks where 176 physicians and some 277,000 patients are already enrolled. This, of course, is just the beginning.

I want to talk about access to diagnostics. As I mentioned earlier, another key priority that arose from last summer's public dialogue is access to diagnostics. This government shares that priority and has a demonstrated track record in enhancement of those diagnostic services. Simply put, we're committed to improving access to timely treatment and quick, accurate diagnosis so Ontarians can get the care they need where and when they need it.

In 1995, there were 12 publicly funded MRIs in the province. Over the last seven years, we've approved no less than 32 new MRIs, bringing the total in the province to 44. But we're not finished.

In this year's throne speech, we committed to continue to add to the number of MRIs and to increase their OHIP-funded hours of operation. I'm proud to say that this July I announced plans to provide up to 20 new MRI machines and five new CT scanners, and this year's budget committed an additional $28.3 million to increase the hours of operation for the existing hospital MRI machines. That's an increase of 90% of their funding.

Thousands of patients across the province will benefit every year from this investment. It means that the latest diagnostic tools will be available to patients faster than ever before, reducing the frustration and the stress inherent in wait times.

I'm also pleased to report that over the past two years we've directed more than $380 million to purchase new medical equipment as part of the federal medical equipment enhancement fund. The money that we have used has been used in a variety of settings, including hospitals, regional cancer centres, independent health facilities and community health centres. This funding helped to acquire and install diagnostic and treatment equipment, helping nurses and doctors provide more effective treatment.

This year's budget also supports an increased investment in what we call telemedicine. Telemedicine is a term we use to describe the delivery of health services and the transmission of information using telecommunications for clinical and educational purposes. This year's investment will help build on current projects and work toward ensuring that telemedicine activity in Ontario is coordinated, sustainable, cost-effective and consistently provided across the province, particularly to rural, northern and underserviced areas.

I want to talk about wait times. When it comes to dealing with wait times, the central issue is building system capacity. While our commitment to increased diagnostic services is a huge step forward in this respect, it is our hospitals that of course lie at the heart of the system. Hospitals work in concert with patients, with the community, with front-line providers and with one another, and the more effectively they work, the fewer people have to wait for care.

I'm pleased to report that this year's budget ensures Ontario's hospitals will continue to provide the very highest level of patient care, building on the 88% of Ontarians who rated the care they received in hospitals as good or excellent.

During 2002-03, the province will spend a record $9.4 billion on hospitals. That's a 7.7% increase for the hospitals over the past year. Such unprecedented support will help hospitals in their continued mission to provide timely access to the full range of hospital care and treatment. We're well aware that these new and vital activities need to be organized coherently across the province, and that's why we continue our engagement in the largest hospital restructuring exercise in the country, ensuring a modern, effective and efficient hospital system.

As we discussed in this year's budget, we face major challenges in new capital investment in hospitals and other health care facilities even though we have already invested $2.5 billion to expand, modernize and build new hospitals, and support community health infrastructure.

In 1995, after the decade that we inherited, where we had a broken system with empty corridors and outdated equipment that weren't serving patients or professionals well, we decided we had to reinvest and redesign the system to protect the universal access and to serve Ontario's patients better. This year we will continue to work closely with these health care partners to facilitate the implementation of the Health Services Restructuring Commission directions. While all of the HSRC-directed hospital governance amalgamations have been completed, there is still considerable work to be done. Hospitals across Ontario are at various stages of capital project implementation, including functional programming, design, tender and construction. To assist them, this year's budget contains an additional $153 million for health capital, which is an increase of almost 80% over last year.

Right now, I would like to address how we are also targeting specific programs to improve waiting times.

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Patients with the most complex or unstable conditions require active medical management of their care, frequent medical interventions and technologically based hospital care. Since the year 1999-2000, we have put 543

new rehab beds into operation. We plan to add another 564 beds over the next four years. This is a first step in reforming our rehabilitation system to ensure that patients receive appropriate rehab services faster.

We've also directed $9.6 million to expand and evaluate cardiac rehab centres in Ontario, based on the report of the consensus panel on cardiac rehabilitation and secondary prevention. Since 1995, this government has approved more than $186 million in new funding to support roughly 69,000 additional cardiac procedures. Our plan encompasses a continuum of services from heart disease prevention through diagnosis and treatment to cardiac rehabilitation.

When it comes to emergency health services, every Ontarian deserves access to an ambulance when they need one. Just last month, I announced $32.5 million to enhance emergency health services by creating positions for over 500 more paramedics and 66 new full-time-equivalent dispatch workers. Together, they will help alleviate ambulance pressures, improve ambulance response times and, overall, improve the delivery of emergency health services.

We continue to work with Cancer Care Ontario and the University Health Network/Princess Margaret Hospital to reduce Ontario's cancer wait times. In the 2002-03 budget, I am proud to say we have committed to further increasing support for cancer patients. Increased funding of $50 million will be provided over three years to enhance the Ontario cancer research network, doubling the number of patients who can benefit from this research, and $29.5 million will be provided to modernize and upgrade cancer radiation equipment.

This year, our total funding for Cancer Care Ontario is $312 million, a 27% increase over last year. This means cancer patients will receive care more quickly, using more effective drug treatments. It will also be used to purchase new, leading-edge anti-cancer drugs to combat breast cancer, ovarian cancer and lymphoma. Patients from Ontario who suffer from lung, prostate and colorectal cancer will also benefit from this funding.

We also reduce wait times by improving access to medical services. Alternative funding plans, or AFPs, as we call them, are used to provide flexibility in practice, encourage coordination or integration, improve compensation for highly specialized groups, and assist with retention and recruitment of physicians. The ministry currently manages more than 260 contracts, valued at over $445 million, with more than 3,350 physicians participating in some capacity.

This year, increased funding will be particularly focused on emergency department services, specialists in northern centres, specialized pediatric care and physicians in academic health science centres.

Furthermore, as you know, in 1996-97 we created 43 community care access centres across the province to provide a simplified entry point for people in need of community-based long-term health care. In the 2001-02 year, Ontario spent nearly $1.2 billion for services provided through CCACs, and some $1.6 billion on long-term-care facilities. Ontario's spending on home care has increased by nearly 70% since 1995.

Since 1998, Ontario has been engaged in the largest-ever expansion of long-term health services in Ontario's history: a $1.2-billion plan to improve long-term-care facility and community programs over six years. Some $600 million of this investment is directed toward long-term-care facilities to meet the increasing care requirements of residents and the growing numbers of elderly people requiring care.

Our plan has always been to provide the health services we need not just for today but for the 21st century, as we progress through that century. We are making room for Ontario's growing and aging population, building new long-term-care beds and rebuilding existing beds in our system.

I can report to this committee that to date more than 6,600 new beds have been built and occupied and another 13,400 are currently under development or awaiting municipal approval. We have also rebuilt more than 2,000 existing beds to comply with current standards and more than 3,700 are currently tendering or under construction.

Today's new design standards feature a more home-like environment and promote a better quality of life for residents. I'm sure many members of this committee have visited the new facilities in their communities and can attest to this fact.

This year's budget provides nearly $100 million to continue the expansion of long-term-care beds. As we can all appreciate, more beds mean less waiting. It's a simple equation. We are also reducing wait times through changes we made this year to long-term-care placement coordination services. Those changes mean that bed vacancies in LTC facilities will be filled more quickly by people with the greatest need of facility care.

In the remaining moments I have left, Mr Chair, I would like to talk about health promotion and wellness.

The Chair: Minister, before you make that transition, if it is possible, at least one copy of the minister's remarks would be helpful for the subsequent proceedings, if that could be passed to the clerk.

Hon Mr Clement: By all means, Chair. Thank you for that point.

The Chair: Please continue.

Hon Mr Clement: People told us to keep people healthy in the first place before they get sick. So one responsibility of a modern health system is to show people how they can lead healthy lives and indeed stay healthy. That responsibility bears a double accountability. It takes both the system and its users to make it work properly. It means we need to encourage people to ask themselves difficult questions such as, "Am I healthy right now? Am I making good decisions about my health? Am I making good decisions for my children about healthy practice and healthy diet?" And of course we need to help people answer those questions and to take action on those answers.

With this in mind, our government will continue to focus on public health promotion. We know that most illnesses and premature deaths are preventable. For example, in Ontario it is estimated that more than 25% of all deaths attributable to cancer are due to tobacco use, poor nutrition, physical inactivity or alcohol consumption. There are few people who are unaware of the impact of smoking, the leading preventable cause of premature death, disease and disability.

Health promotion and disease prevention programs pay off by creating a healthier population, reducing human suffering and financial stresses of the system and strengthening the system's sustainability in the long run.

I am proud to say that Ontario leads the way in a number of excellent prevention programs. For example, a baby may be born with Down's syndrome or have a congenital heart defect. A six-week-old may not be turning its head toward noises. A toddler may be a late talker. We are committed to ensuring that these children can still achieve their best. Supported by annual funding of $74 million, the Healthy Babies, Healthy Children program is in place to help address the well-being of Ontario's children and give them the best possible start in life. Any one of these or many other problems sets in motion a network of community resources to help.

As well, we have an innovative $44-million program that has made free flu shots available to everyone in this province in each of the past two winters. Still the only program of its kind in North America, it aims to keep people healthy and reduce pressures on family doctors and emergency rooms. As well, we are investing an additional $9 million to support West Nile virus surveillance and prevention this year and indeed that program is in full swing as we speak.

Chair and colleagues, I can elaborate, in the presentation, on our healthy programs with respect to heart health, our stroke program, our program with respect to rehabilitation of stroke victims, our program when it comes to asthma and action, our program with respect to mental health programs and services, including new community-based services and homes for special care and general psychiatric care. All of these are new initiatives since 1995 and indeed show that we have placed our emphasis not only on hospital care but also on community-based care.

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Our success in Telehealth Ontario, another program that helps ensure that our emergency rooms are not overcrowded, is as well a signal program for the past year and indeed is supported by an annual budget of $45 million this year.

In the remaining moments of my time, I wish to commit to you that health care must and will remain a priority for public funding now and in the future. It has grown, in terms of budget, from $17 billion in 1995 to $25.5 billion this year. Again, health care spending is rising faster than our economy. Indeed, at the rate we have experienced over the last few years, we are well on our way to approaching a budget that represents 60% of Ontario's program spending, given current rates of expansion, in the next few years. Right now it's 47% of program spending, up from 38% when our government was first elected. That means our federal partners have an important role to play when it comes to sustainability.

The Chair: Minister, I wonder if I can pause you.

Hon Mr Clement: On that note, we'll leave it to the questions as they come forward. Thank you for your time and your consideration.

The Chair: Thank you for that effective transition.

We will now turn to the official opposition. Mrs Pupatello?

Mrs Sandra Pupatello (Windsor West): Thank you. I'll be sharing my time with members from the Liberal caucus as well, Chair.

The Chair: To the official opposition and third party, you may use this time to speak, or you may, with the indulgence of the minister, go right into questions. It's up to you.

Mrs Pupatello: I think we'll have some brief remarks and commentary. We'd appreciate getting a copy of the minister's remarks. If we could have that distributed to committee members this morning, that would be super.

The Chair: We've requested that and I understand it's forthcoming.

Hon Mr Clement: Yes. I had some late changes, Chair. I apologize. We'll get you an up-to-date copy.

Mrs Pupatello: OK. We are happy to hear some of the reporting from the minister, at least his opinion of what has transpired over the course of government since 1995.

To do a brief review, when this government took office, they initiated a restructuring health services committee that went through the province and essentially restructured hospitals and had a huge impact on most community services involving the health sector.

We recall that time well, because under the chairmanship of Duncan Sinclair, he promised communities across Ontario investment in community programs and services in the health sector before there would be changes in hospital and institutional care. We remembered that very well, because many of us come from many of the communities that were changed dramatically in terms of how services would be delivered in Ontario.

What this government failed to do, from 1995 on, was to understand the function of funding the right place at the right time in the health sector. While this minister may not have been the minister at that time, he certainly was part of that government that created enormous panic and long waiting lists and loss of personnel in the health sector because of the policies of this same government. They in fact refused to fund the community. Even though services were being forced into the community, the services in the community were not ready to accept them because they hadn't been expanded to deal with that massive increase in volume. Probably the best example of this is the home care sector.

This government launched a change in how home care services would be delivered in Ontario. Once hospitals

essentially were forced, through new utilization levels, to throw patients out quicker and sicker back into their communities and into their homes, there was a dramatic increase in demand for home care services. At the same time, this government undertook to restructure how they would deliver home care services. They went to a bidding process, invited the private sector to play a larger role in this, all the while not understanding that the demand was increasing wildly, and increases that this government was sending into the home care sector were simply not meeting that demand.

The result was quite dramatic. The result essentially pushed people out of the nursing field. So while we are facing across the nation a significant loss of staff due to the age of the staff—we know that the nursing sector, for example, is under tremendous strain; we don't have enough of them; we're not graduating enough of them—but coupled with that, in Ontario they also had to deal with government policies that pushed them out of the sector. They were being laid off in droves from hospitals because of budget constraints at the hospitals. In the long-term-care sector and in the home care sector, we gave them such tremendous and difficult circumstances to work in that we were not making it a pleasure to be a nurse in the field. So we're having a struggle getting people to come into the nursing sector and stay.

Border communities are probably the best example of this. While I would visit nursing classes every year and ask these graduates where they intended to work, often not one hand would go up when I asked who planned to work in Ontario. There is such a tremendous drain in Ontario to places like Michigan and Texas and these massive commercial enterprises that are coming up to essentially pillage us. After we've expended the time and energy to train—and we have a well-known training program across the province—we're losing people instead of gaining them.

So our biggest fear for the future, for what we see in this next year and up until this next election, is that the government doesn't seem to be funding the right way in the right places. Instead, as we're in a year before the next election, you realize you've got a lot of patching to do, a lot of patchwork, and you will start throwing money around for the political purpose of becoming re-elected, as opposed to good health policy for Ontario.

Primary care reform is probably the best example of this. Several years ago, this same Conservative government started a goal of 80% participation in primary care reform. Today we're at 3.47%. Yesterday at the minister's press conference, he suggested that this was landmark and trailblazing. Minister, my comments yesterday were that I believe you're going to need divine intervention to reach an 80% goal in primary care reform.

We realize that the system needs a much better way of doing things. While the minister seems to be using the right words in the various headings and in the various organizational charts within the ministry, of integration and better use of professionals in the field and allied professionals working for primary health centres and primary care networks, the minister simply is not coming to the table. The minister is busy at ribbon-cuttings, introducing new primary centres that only include doctors. He went to another yesterday to announce four new primary care networks that include only doctors. I think this ministry is actually advancing the moving business, because we're having doctors move into new facilities but we're not changing the way they do business.

Until we change how primary care is delivered, which is a real and better and optimal use of all the professionals, we're not going to save the ministry the money it thinks it would save, nor are we going to be better for the consumers of Ontario. And that's really got to be the goal.

I think with the survey that the minister spent millions on to get his 10% return, I was convinced that you made the card too small when you asked the public for their opinion about the health care system in Ontario. I know, based on the copies I got in my office, that people spent time writing along the bottom, up the side, along the back, and there was not a computer system in the world that could have introduced that information into your survey result. They had much to tell you and they were, in fact, very constrained about what they were allowed to tell you in that card that you sent around and spent millions on to tell you what your loyal opposition has been telling you for seven years: that access is paramount. People want to have the care they need when they need it. The Ontario Liberal Party has long believed that primary care reform is key to this and still, even as late as yesterday, the minister didn't understand that announcing four new doctors' offices doesn't bring us any closer to primary care reform or to his own 80% goal.

Several of the issues that were raised in the survey results have been repeated and repeated in the House over the course of the last seven years, and now into our eighth year. The universal access, the lack of personnel across the board in the health sector is absolutely paramount and the public has continued to speak on this. On every issue it comes down essentially to those two functions.

1000

This minister this morning spoke about the two new medical sites in the north. Are the new students already enrolled there?

The minister mentioned the site that would be in southwestern Ontario. There hasn't been any money that has flowed for this program yet, and Western hospital is struggling to make sure that happens. In our community of Windsor, which ought to be a major part of that southwestern rural training centre, we can't find the family doctors who would be prepared to take these trainees on so that they can learn. That's because we have such a severe shortage of family doctors, they don't have the time or wherewithal to take those positions on. So where will they go? How are we going to get these trainees to potentially come back and practise in such a severely underserviced area?

So while I appreciate that he has taken this first half-hour to repeat the various announcements we've had, I would have liked to hear the minister focus on how he intends to address the many problems that still exist with the announcements that we have had over the course of the last seven years.

In the area of nurses, while we mentioned primary care reform—we understand that you'd like to double the number of nurse practitioners, but, Minister, we would have liked to hear how you intend to fund nurse practitioner positions in Ontario. What is the point of training them if we're not going to use them to their optimum? That would be just a waste of money. It's a terrible tease for these nurses to train them and then have them underworking in some position as opposed to—in your announcements yesterday of your four new primary care networks, not to have included nurse practitioners was such a missed opportunity.

Access to diagnostics: It's notable that the minister didn't discuss the involvement of the private sector and private individuals paying for the use of the new MRIs that he's selected to announce since July. The 20 new ones in fact created quite a stir in the public's mind because the minister will now allow, by effective policy of the ministry, queue jumping for the use of MRI. And when the minister was specifically asked by the press, "Will individuals be able to pay?" the minister responded that that would indeed be the case.

Minister, we have yet to find a piece of evidence that suggests that this will result in anything other than queue jumping—in fact the contrary: we have found volumes of evidence where it's existed in other places that it will in fact be queue jumping here in Ontario. So while you talk about universal access, what you've actually done is limit universal access.

You spoke about the billions of dollars that you're going to send to hospitals. The minister failed to talk today about the multi-year funding model that he himself has promised since he's become minister, let alone the government itself having promised multi-year funding, but we expected to hear that. In the last several months, under a new Premier in Ontario, we expected to hear multi-year funding, but that was not announced today.

This new operating money that is being assigned to hospitals—I'm curious to see how much of that will be used to finance the debt charges that are being racked up across hospitals in Ontario. We know that operating dollars in hospital budgets are now being used to finance the debt they're incurring at a local level. Ontario in its history has never had this level of debt at the hospital level like we've seen under the Conservative government. I have visited hospitals in Ontario and we do have empty corridors here. That's because the hospitals, still with their debt, are not able to open the beds they require. And that's why still today we have emergency rooms that are full. The minister will likely be interested to take a canvass of hospitals and the new policies in some of them around emergency room use.

We have an anger management policy in one of the hospitals in the north that would allow the staff of the emergency room to call the police if there's anyone that's really angry or being aggressive. This is something that Ontario has never seen but we have it today in an Ontario hospital. In a hospital in southwestern Ontario we have now adopted a new pain protocol which would allow a nurse to administer pain medication in the waiting room because they can't get the patient into the room. They're going to do it in the waiting room so these people, at least while they're waiting in the waiting room, might have some kind of pain shot to make the wait more manageable.

So while we're talking about hospital financing, we still are not addressing, Minister, real issues that are affecting Ontarians, who are looking for good care.

The minister talked about wellness and prevention. One of these programs that we had at the London Health Sciences Centre, for example, was the gastro surgery that is commonly known as "stomach stapling." The doctor who performs this procedure there is very well known for assisting the very obese at this centre. The hospital there just determined all on its own that it was going to eliminate this service because it was available in other centres in Ontario. The reality across Ontario is that there's a waiting list of up to two years for this surgery.

This is the kind of preventive medicine that is necessary for many people in Ontario but is virtually ignored by this minister. Even when that issue was raised in the House, we didn't have an answer. I'd like to know, of all of the staff who are here today under the auspices of the minister, which department, which assistant deputy minister is responsible to see that hospitals which make arbitrary decisions to delete services—who looks out in the bird's nest across the province to say, "This is the level and type of service that we expect to have in each region"? Who says that?

The best example of this might be the hyperbaric chamber that's going to simply be eliminated for the next 15 months here in the greater Toronto area. That's a very arbitrary decision because the service may be available elsewhere in Ontario. Where in your massive $25.5-billion ministry, Minister, is the individual or the department responsible for saying, "This is the service level we insist on having in every region in the province"? It doesn't exist. While the minister has been asked the question, in this case about the hyperbaric chamber in Toronto, we don't have an answer, and we don't have a department to call that says what will be cut and where and that says what service will exist and where.

So while we appreciate that this minister is well-meaning and wants to have services provided, on the ground where services are being delivered, I believe the minister has to have a hand in saying what will exist and what will be eliminated. To wash his hands of arbitrary hospital board decisions is simply not acceptable.

I'd like to allow some time for my colleagues as well to complete that 30 minutes.

The Chair: Thank you, Mrs Pupatello.

Mrs Lyn McLeod (Thunder Bay-Atikokan): As the minister may have observed, our approach in this opening segment is to get a number of issues on the table. We

are going to return to very specific questions. You may feel as though you're being rather inundated at the moment. I'm going to add one issue and then turn it over to my colleague. I will put my issue on the table in the form of a very specific question, and I would appreciate a response, if not in this segment, in the next one.

The concern I want to raise with you is the northern health travel grant program. You know the history of this, so I won't go into it. As northern representatives, we have worked for a very long time on behalf of our constituents to have the inadequacies of the northern health travel grant program acknowledged and addressed. We were somewhat gratified that there was an increase in funding for the northern health travel grant program announced over the course of the past year.

When I looked at the estimates book, however, I saw the increase in the program reflected in the difference between last year's estimates and the actual expenditures. Last year's estimates were $6.8 million, and the expenditures were $11 million. That seemed to me to be fairly consistent with what you might expect, given the 50% increase in the allowances.

What shocked me, Minister, was to see that the estimate for next year is back to the amount it was in last year's estimates prior to the announcement of the increased funding. So my very specific question to you today is, are you going back on the announcement or are you planning to curtail the number of people who qualify for the grant in order to ensure that your announcement of increased allowances for the travel grant doesn't actually allow for an increased budget or lead to an increased budget for your ministry?

Hon Mr Clement: Would you like me to answer now?

Mrs McLeod: I'm going to leave it at that one question. So if you have a response now, I would appreciate it.

Hon Mr Clement: I will maybe have to answer it in two parts while we research that specific issue, but I can tell you that my understanding of the northern health travel grant is that it's based on meeting a certain set of criteria. As in certain aspects of the health care budget, it's open-ended after that.

Mrs McLeod: Maybe I can spare some time and we can come back to it with a response. Because you're absolutely right: it's open-ended. There are certain criteria, and given the announcement of the increase in the grant for each individual who applies and qualifies, there's absolutely no way you can run the northern health travel grant program next year at the same $6.8 million you estimated for it last year. So we want to know why you put in that money, that estimate.

1010

Hon Mr Clement: It would not be a case of changing the criteria in mid-stream. It would be a case that there's a place holder—sometimes we put place holders in the budget. We'll research it, but I'll give you—

Mrs McLeod: OK. I'll look for the answer. But the place holder at a very minimum should have been last year's expenditure, otherwise I'm very suspicious about some cuts to this program.

Hon Mr Clement: I can give you my assurance that we're changing the criteria, if that's what your concern is. But we'll give you a more specific answer.

Mrs McLeod: Thank you. I'll leave the balance of the time to my colleague.

Mr John Gerretsen (Kingston and the Islands): How much time have we got left?

The Chair: You have approximately 10 or 11 minutes.

Mr Gerretsen: Thank you. I'll take the Chair's word for that. I'd like to turn to the long-term-care situation.

But before doing that, one of the other issues I've been extremely interested in and concerned about—and I noted your comments with respect to the foreign-trained doctors who, in my opinion, we're simply not utilizing enough in this province. The same goes for nurse practitioners: I can't for the life of me understand and the average person out there cannot understand why we have close to 400 or 500 registered nurse practitioners, people who have the requirements, but we're only funding half of them, particularly when we have such a large shorting of doctors and medically trained people in underserviced areas. Is it just a question—I'll put it out here hypothetically and you can answer it later on—that the ministry simply has decided that it doesn't want to fund these positions at the levels they should be funded?

It's exactly the same question with respect to foreign-trained doctors. Even in a community like my own we have 10,000 to 20,000 people who do not have a family doctor, who simply are unable to get a family doctor. I come from a part of the province that has one of the five medical health science centres, and presumably everybody would assume there are enough doctors. But there are 10,000 to 20,000 people in my immediate area who do not have a family doctor and are unable to get one. Why are we not more quickly qualifying people who are foreign-trained and meet our qualifications? When I've asked this question in the House a number of times of you and of your predecessors, the answer has always been, "Well, that's up to the College of Physicians and Surgeons; that's up to the OMA." It's always up to some other group. Now, all of a sudden, I take it that you obviously do feel some responsibility, because you've allocated funding for 40 of these positions, if I took your comments correctly.

Why aren't we getting together with the necessary bodies that do the approval mechanisms to get as many of these people as possible qualified and get them out in the field where they're needed, both in the nurse practitioner area and in the foreign-trained doctor area? Is it just a question of money, that basically you don't want to give the doctors OHIP numbers so they can start billing the system? What is the problem there? That's what the average person out there would like to know. Maybe in your response later on, Minister, you could address that.

I'd like to deal with the long-term-care situation. I've been in public life in one way or another for 25 to 30

years, and I can't ever remember an issue that caused as much fear, anxiety and distress among the residents of nursing homes, and I've visited many homes, probably between 15 and 20, mainly in July, during that period of time—the amount of distress that many of the residents and many of their caregivers, primarily their children, had about what was going to happen to their parent as a result of the 15% increase that you initially implemented. I know you'll come back and say, "We backtracked from that and we've now decided to make it 15% over three years rather than 15% all in one shot," which in most cases amounted to something like $230 a month. I would like to know what the thinking was, what you or whoever came up with this idea were thinking, to try to implement this and try to get this out of people, most of whom are in their late 80s and early 90s, people who have lived primarily on fixed incomes for the last 20 or 25 years.

I heard from many individuals who had worked for governments, both provincially and federally, who had retired 25 years ago, people who have always paid their way in life, people who have never asked for anything from the system at all, who were basically telling me, "Mr Gerretsen, I don't want to fight with the government, I don't want to fight with the home here, I don't want to get politically active, but for the first time ever I'm going to have to go on some sort of subsidy system because I cannot afford the additional $230 per month."

So it's nice of you to come here and talk about the 6,600 new beds that have been created or that are in the process of being created. I can tell you that the anxiety level that you and your government caused by making that announcement the day after the House rose in June, when in fact the cabinet had approved this at some time at the end of May—I don't know what the normal procedure is, but it's my understanding that usually when a decision like that is made, it's gazetted and everything else within a week or two, but somehow, somebody sat on this for four weeks so it could be announced the day before a long weekend. That may be just a minor issue and a temporary issue, but I can tell you that it tells an awful lot of people what was really going on and the kind of contempt, quite frankly, that the government appears to have for the senior citizen population that resides in these homes.

I know the argument can be made, "Well, nobody was going to get kicked out," and that's a given. But a lot of these people have never wanted anything from the system, they've always paid their own way, and all of a sudden they were placed in the position where they were going to have to be placed on some sort of a subsidized system and they don't want that. Many people fear the fact that they may be taken out of their private accommodation and put into a semi-private room, or out of a semi-private room into a ward accommodation.

Petitions have been taken up, not only by ourselves but also by other parties, by interested groups out there. We've already got petitions that total some 25,000 to 30,000 names of individuals who are concerned, and they're still coming in. Even though you may have backtracked from that to some extent, an awful lot of people simply cannot afford even the 7% increase that you implemented this year. CPP increased this year by something like 3%; the old age security by 0.3%. That is a lot of money to these people. You and I and everybody else in the room who makes good money can sit here and think, "What's the problem? What's an extra $100 per month?" To these people, $100 per month meant everything. I would like to know why you just take the other step and reduce it even further, to the point where it will be no more than whatever the cost-of-living increase has been this past year.

I find it very—how shall I put it? You keep talking about the $100 million that you're putting in, but you and I know that over $50 million of that money comes right from the seniors, comes right from the residents. That's not government money. That's money that the seniors, the residents themselves, are paying as a result of the $3.02-per-day increase that you're implementing. If not, then I'd like to be corrected on that. But it's my understanding that the $3.02 that in fact the individuals are being charged—I understand that of our population of 60,000 people who live in the homes etc, it will affect 50,000 people, at $3.02 a day times 365 days—amounts to something over $50 million. So when you keep talking about investing $100 million into the system, $50 million of that, if not more, comes from the seniors who live in those places in the first place. Let's be honest about it. Let's not make it sound as if the government is doing these wonderful things for people when in fact the people are paying for half of that themselves.

I'll just leave it at that. I don't know whether my time is up or maybe Ms Pupatello has a—

The Chair: Two minutes.

Mr Gerretsen: It's a major concern with the seniors out there. Surely to goodness, Minister, you will agree with me that we owe seniors, who have contributed so much to the lifestyle that we enjoy in this province today, better than that, the kind of fear and anxiety that you and your decision caused them and have continued to cause them.

1020

The Chair: There's approximately one minute left.

Mrs McLeod: If we have a couple of minutes left, I'd like to put a couple of issues on the table.

Minister, I know that from my community at least, and I suspect from a great many communities, you've been hearing the concern from agencies that are providing respite services in the community that there have been no increases in their base budgets for at least 10 years. You have been asked to look at the financial hardships, at the decreasing ability of these agencies to provide respite care to individuals who need those services, and yet there has been a negative response to any requests for increases to base budgets.

Given my awareness of that, I was really quite struck, again, by another figure in the estimates, and that is the underspending last year in community support services—which you'll find on page 71—where, if I'm doing the

subtraction correctly, you underspent by about $50 million.

I have no understanding of, I cannot grasp, how you could be saying no repeatedly to agencies providing community support services when you claim that you're trying to move care from institutional-based care to the community, and yet you underfunded by $50 million last year.

The Chair: We'll now turn to the third party.

Ms Shelley Martel (Nickel Belt): Minister, thank you for being here today. I'm sure there's nowhere else you'd rather be for seven and a half hours. I should just tell you there's nowhere else I'd rather be either on this, my 15th anniversary in politics. So we will—

Applause.

Ms Martel: Thanks. That's right. So here we go.

I'm not going to make a number of comments. I would like to get to questions. But I want to deal with what is probably the most important issue at this point in time in our community, and that is what is happening with our regional hospital.

The chair of the operational review steering committee was in the media about 10 days ago announcing that for all intents and purposes both the capital and operating review were done and he expected to table that with the ministry in about two weeks. So I wonder if you can tell me if that report by Mr Aubé has actually been tabled with your ministry now.

Hon Mr Clement: Gail Ure, who is the executive director of health care programs.

Ms Gail Ure: In terms of the hospital operating review in Sudbury, the report has not been tabled yet. The last meeting was held August 27. We're awaiting the final report.

Ms Martel: When that report is tabled, can you tell me the process that the ministry will undergo both for (A) review and (B) for more public disclosure to the community of the contents?

Ms Ure: Absolutely. First of all, we had members on the committee. So in addition to the independent chair, Mr J.P. Aubé, we had members of our staff, both from the northern office as well as the corporate office, on the committee. Recommendations will be made by the consultants. It's a consultants' report. Once the final report is available to us, there'll be a review within the ministry and then it will be presented to the minister, and the minister will make a decision with respect to distribution and other issues.

Ms Martel: Both in terms of recommendations and disclosure?

Ms Ure: That's correct.

Ms Martel: I appreciate that information. Maybe I can make a couple of comments just about the review.

I have a lot of respect for Mr Aubé. When I was chair of the northern Ontario heritage fund, he was one of my board members, so I know him very well. However, I really can't accept the proposition that the community will have to fundraise even more for this project.

I understood what you said, Minister, about hospital restructuring, but I really think that the Health Services Restructuring Commission grossly underestimated both the capital expenditure required for this amalgamation and the equipment expenditure. Frankly, that was the case not only in Sudbury but in a number of other northern communities: Thunder Bay, the Soo and North Bay, just to name a few.

The community has already raised a significant portion of the money that was required for what we thought was the original capital cost. We are raising money right now for this hospital, for the expansion of the cancer treatment centre and for the new long-term-care beds that the Sisters of St Joseph will operate. The target is $17 million, and we are well on our way. The proposition that we will have to fund even more I think is just really unacceptable for me, as a community member, and for the community at large.

I would say to you, Minister, in all frankness and honesty, that I really think the ministry ought to consider once again a difference in the cost-sharing. This is a hospital that operates as a regional hospital but it is people in our community, from their tax base and from their fundraising efforts, who are paying for it, because the sources for that are two. There is no way to charge people who are coming from other communities to use the service, be it cardiac, cancer, neonatal, trauma, and all of those are served for all of northeastern Ontario.

I don't know what the outcome will be. I only know about the public comments, and I say, on behalf of the community, that I really think you need to reconsider how this is cost-shared for the rest of the capital project, both for the end of the first phase and then for the second phase. I would request again a consideration of an 85-15 split, to recognize that indeed this is a regional centre that services not only Sudbury but all of northeastern Ontario.

In the same way, with respect to the operational deficit, which runs between $28 million and $30 million, I think a large part of that deficit is due to the fact that we do operate as a regional centre but are funded primarily as a community centre. I could be wrong about the numbers that Mr Aubé will come forward with, but that has certainly been the belief I've held. I would encourage the government, as they look at this review, to take into consideration the fact that we do operate regional programs and, on an operating basis, need to be funded the same.

Let me leave you with those comments, Minister, and remind you that it is an extremely important issue in our community right now. There hasn't been construction going on since November. It's very painful to see two towers, and very little in between to join the two towers, in the community. It becomes difficult to continue to fundraise under that circumstance as well. We need this uncertainty dealt with and we need an additional funding commitment from the ministry.

I want to deal with long-term care, the 15% increase for residents living in long-term-care facilities. Minister, the agenda actually noted that Minister Newman would

be joining us, and I assumed that would be to answer those questions. But he's not here, so I'm wondering if you are answering the questions then with respect to long-term-care facilities.

Hon Mr Clement: I'm not sure what agenda you're referring to.

Ms Martel: The agenda the committee received, the list of people who would be participating today, has both.

The Chair: Attendees supplied by the ministry.

Hon Mr Clement: I don't know why the ministry did that, because that was never the plan, so the ministry is wrong. There's one budget and one Minister of Health and Long-Term Care. I'm happy to answer any question you have.

Ms Martel: All right. I want to ask a number of questions around the 15% fee increase. The question I want to start with is how the government arrived at a figure of 15% as an increase for accommodation for residents. What went into the thinking to arrive at a fee increase that, frankly, is far above what people would be receiving from CPP, old age security etc, and far above what the guideline would be if this were the rental housing market?

Hon Mr Clement: We always are comparing and contrasting with other jurisdictions in Canada. Certainly from our understanding, the copayment aspect is of course based on ability to pay and on income levels going into the system, and an assessment of those income levels is done on a regular basis. There was a comparison done of Ontario with other provinces and territories, and the conclusion that was drawn was that we were in the low end of expectations when it came to copayments. Once fully implemented, this copayment, which again is income-based, would put us around the middle of expectations by provinces and territories.

That sounds quite technical and so on. The second, more important, driver was our conclusion that the amount of nursing care available in the long-term-care sector should be increased. The conclusion was that as a Ministry of Health our budget, which for historical reasons was split between nursing care and accommodation, should be reallocated less to zero on accommodation and more to nursing care. That's what our role and responsibility is: to provide for the nursing care associated with long-term-care facilities. So a combination of those two policies, I would say, would be the discussion that we had with government officials and with the caucus and so forth.

1030

Ms Martel: What analysis was done to determine the impact on residents? I mentioned to you that this hardly reflects what they would normally see as an increase on an annual basis, and it doesn't reflect what you would allow as a government in the rental housing market, for example. What work did the ministry do to determine what was the financial impact that people were going to face?

Hon Mr Clement: I'm not sure—are you referring to the initial policy or the subsequent policy at this point? We were on to the subsequent policy.

Ms Martel: I appreciate that the 15% payment has now dragged on over three years, but it is a 15% increase, at the end of the day, over a three-year period. That's not going to change, unless you're going to change your mind over the next two years. So we continue to look at a 15% increase that over a three-year period is much higher than anyone can expect to achieve in terms of their pensions, much higher than the rental housing market and, I would think, a significant burden for thousands of seniors in these facilities.

Hon Mr Clement: I will defer to Mary Kardos Burton to attend at the microphone, but in the meantime, as she is making her way there, I can tell you that certainly the phased-in approach that we have embarked upon is still based on ability to pay, still based on income availability in order to meet those increased requirements. So it's based on our calculations and the individual's calculations on what income is available for accommodation, which is something we think is important for the individual to have some responsibility for, to be responsible for, if the income is there. Consequently, it allows us to reinvest in nursing care, which we do believe there is a societal responsibility for. But if I can defer to my assistant deputy.

Ms Mary Kardos Burton: Good morning. I'm Mary Kardos Burton, acting assistant deputy minister, health care programs. I think you were specifically asking about the kind of work that was put into reviewing the options. As the minister said, we looked at a variety of things. First of all, in terms of the copayment, we did look at other provinces and we also looked at the amount of nursing and personal care money that was required. You will know that particularly the Long Term Care Association had a massive campaign underway and their request was for some $750 million over a three-year period. So that factored into at least considering where the money needed to go when we were looking at the money for long-term-care facilities.

In looking at the copayment, there was work done and, like anything else, there are always options put forward. But the factors taken into consideration in putting forward the options would be the numbers of people who are on OAS, GIS, a person's ability to pay. There was never an intention that anyone who couldn't afford it would have to pay. In fact, the intention was that people would always get a subsidy in terms of those who could not afford to pay. Those were the main things that were taken into consideration in developing a policy to put forward, but the primary intention was more money into nursing and personal care.

Ms Martel: How many residents are affected across the, what, 63,000 in long-term-care facilities?

Ms Kardos Burton: There are about 61,000 residents in long-term-care facilities currently. I don't have the exact percentage in terms of the lower number, but it is not that high.

Ms Martel: Fifty per cent? Thirty per cent?

Ms Kardos Burton: I don't want to speculate at this point.

Hon Mr Clement: Can we undertake to get that? There is a number. I know there's a number, but I don't have it off the top of my head, so we'll get that number.

Ms Martel: OK. There may be a number here. I would like to know how many residents have been affected, obviously.

Ms Kardos Burton: Yes.

Ms Martel: I'd like to know, then, what is the revenue that is being generated over the next three years with the fee increase?

Hon Mr Clement: Can I just say one thing? You're embarking into an area that is not part of the budget of the Ministry of Health and Long-Term Care. There is no budget item for copayment. This is an item for the individual operators. We have a budget of our own expenditures, but we don't have a budget that has every copayment that is part of the broader health system, so we're getting to the point where we can't answer some questions because it's not part of the budget.

Ms Martel: Correct me if I'm wrong. When this copayment—

The Chair: Just as a technical point, in estimates we allow some latitude, both in your remarks, Minister, that referred beyond the scope of the immediate expenditures—and we're dealing with a general vote item. I'll encourage you to exercise whatever your best discretion is, but from a technical point, we're allowed to have some latitude.

Hon Mr Clement: Forgive me. Again, I'm not trying to cut off the discussion, because it's an important discussion to have, but to know the individual economics of a for-profit or not-for-profit long-term-care facility, you're starting to get beyond the scope of what the ministry would necessarily know.

We can talk about the standards that we set; we can talk about the payments they receive from the Ministry of Health and Long-Term Care. All of that is fair ball. We will endeavour to answer any questions outside of that scope, but I wanted to signal that you're starting to get outside of the scope of what the ministry and its budget entail.

Ms Martel: I guess I don't understand that, Minister. I have asked you for the number of people who were affected, and we should be able to know that. So it seems to me that it's a fairly simple matter to extrapolate from that how many people are affected this year at $3.02 daily and next year at $2 daily and the year after at $2. I'm not trying to make this complicated. Is that not correct? Is that not how this works?

Ms Kardos Burton: There are projections, but they are projections and they're estimates. So obviously in looking at that there had to be some estimates made of what the potential revenue could be. But I'll defer to the minister in terms of whether we proceed further on this.

Ms Martel: I guess I don't understand why that can't be shared. What am I missing?

Hon Mr Clement: We'll give you our best understanding, but I would caution that individual operators may make individual decisions; that is to say, they may be more generous than what is expected and may make individual decisions based on individual cases. So I just want to give you that warning. But we don't, in that sense, operate that part of the system. That's not part of my budget.

Ms Martel: But just so I'm clear, you're trying to say that even though the allowable in some cases is $8 per day—and I know that Pioneer Manor at home, for example, is going to charge $6. Is that why you're telling me you can't make a decision? I always assumed—and someone is going to correct me if I'm wrong here—that when my mother pays for my grandmother for her semi-private room, that cheque goes to Pioneer Manor, and that money goes where from there? The cheque is deposited by Pioneer Manor or it goes to the ministry?

Ms Kardos Burton: The money goes to the accommodation budget for Pioneer Manor in that particular case.

Ms Martel: Is there no accounting that they have to share with the ministry?

Hon Mr Clement: There's accounting, but can I put it this way: the head of Pioneer Manor may decide that although he or she is entitled to exact a copayment of a set amount, he or she may decide to waive the copayment. All I'm telling you is, the operator of Pioneer Manor may make that decision, and that's a perfectly legitimate decision for that individual to make and that is certainly within the scope of their decision-making. That's the only point I'm trying to make.

Ms Martel: But would that not still have to be accounted for with your ministry, reported and accounted for with the Ministry of Health?

Hon Mr Clement: That they waive a copayment?

Ms Martel: What has come in in terms of accommodation from residents in that facility.

Ms Kardos Burton: Yes, we do know the information.

Hon Mr Clement: But if you're asking me what's going to happen in the future—I'm sorry, I'm not trying to be semantical, Chair, but if you're asking me what's going to happen in the future, the most accurate answer is, I won't have all of that knowledge because some individual operators may decide to waive things which they are perfectly entitled to waive in terms of payments and costs. That's the only point I'm trying to make. We will know about that after the fact, but it's not a part of my budget to know that before the fact.

Ms Martel: But you will endeavour to table the projections for us over the next three years, what revenue on the accommodation side would be generated by a $3.02 increase this year, $2 and $2 over the next two and the number of residents you believe are affected.

Hon Mr Clement: Sure.

Ms Kardos Burton: Yes, and there are assumptions that go with those as well.

Ms Martel: Let me go to the press release that was issued on the 31st. This is with respect to the increase itself. The ministry press release says that $1.02 of the increase for long-term-care facilities will be allocated to long-term-care facilities for accommodation. But if I look on the letter that was received by administrators of long-term-care facilities in the other accommodation envelope, it shows an increase in per diem beginning August 1, 2002, of 87 cents. So there's a 15-cent-per-day-per-resident piece that's missing there and I'm just wondering where the 15 cents is going.

1040

Ms Kardos Burton: The 87 cents is the amount that the operators would in fact collect. The $3.02 is $1.02, which reflects the increase in the retirement benefits—that's the OAS-GIS amount—and then there was an additional $2 amount that goes toward accommodation. The 87 cents is the amount that's projected that the operators will in fact collect.

Ms Martel: So it is not a reflection of what the ministry is transferring.

Ms Kardos Burton: No, it's not the same thing. It's just the projections in terms of what—

Ms Martel: I apologize. I'm still not understanding where the balance of the 15 cents has gone, then.

Ms Kardos Burton: The balance of the 15 cents is the subsidy; it's the 87 cents that the actual operator will collect.

Ms Martel: But the release says that $1.02 of that increase will be allocated to long-term-care facilities.

Hon Mr Clement: Sorry, which release are you referring to?

Ms Martel: I'm looking at the ministry press release that came out on July 31st, back page, under the section that says, "Co-payment increase."

Ms Kardos Burton: The $1.02 has been the historical amount that we've paid in chronic care and in long-term-care facilities, and that's the $1.02 that is the OAS-GIS amount that's related to the pension benefit amount.

I'm sorry, I should probably look at that press release in terms of what it actually says; I don't have that. We could also potentially come back with the detail on this one for you.

Ms Martel: OK. Can I ask you a few more questions then about that?

Ms Kardos Burton: Yes.

Ms Martel: The next section talks about a $2 increase as well that will go into accommodation. I don't understand what that means in terms of where that money actually goes.

Ms Kardos Burton: There are three pots of money in terms of long-term-care facilities. They are nursing and personal care, they are for support, and the third one is for accommodation. There are a variety of things. The second one, sorry, is for support services, which includes recreation, therapies and those kinds of things. For accommodation, it goes into a variety of things listed in accommodation. Those would be for physical space, things that would make residents more comfortable in accommodation.

Ms Martel: Just so I clearly understand, the $2 that is being allocated, is that money that's also going to be operated from the ministry? Is that what they're keeping?

Ms Kardos Burton: The $2 will go toward accommodation to the facility.

Ms Martel: I guess I don't understand the graph—I apologize—in the memo that went out to administrators.

Ms Kardos Burton: The $2 is from the residents that will go to accommodation toward the facility.

Ms Martel: That they are keeping. The $2 is coming directly from the residents. The 87 cents that's listed here—

Ms Kardos Burton: The 87 cents is really just the historical collection rate that we have got.

Ms Martel: OK. On the same letter—

Ms Kardos Burton: The difference is that a number of people could afford it, so historically we've only collected 87 cents and the remainder is subsidized. Does that make sense?

Ms Martel: I think so.

If I go back to the July 31 letter—this is a letter sent to the administrators of the facilities—there's a change that I was curious about, and that is that the ministry stated they were changing the funding policy for incontinence supplies, and effective August 1 that would be reported and funded under the nursing and personal care envelope, that $1.20 per resident per day. Why are you making that change?

Ms Kardos Burton: There were actually two changes made. One was medical director fees and one was the incontinence supplies. The facilities had asked of us that they be allowed some flexibility—in order to get more money into nursing and personal care, they asked us, "What can we look at in terms of what goes into nursing and personal care?" It's really that incontinence supplies are now in nursing and personal care, and so are the medical director fees. When you look at how it had been distributed before, both of those functions, you could say, do actually contribute to the nursing and personal care of residents.

Hon Mr Clement: It's a definitional issue. We wanted to work with the industry to apply the most accurate definition of what nursing and personal care was. On its face, it's pretty reasonable to assume that those issues are more in the nursing and personal care category rather than the accommodation category.

Ms Martel: What is the value associated with that change? If that was previously reported under accommodation, does the ministry have an idea of what that total cost would be across the industry?

Hon Mr Clement: What the shift is from one column to the other column?

Ms Martel: Yes.

Ms Kardos Burton: We can certainly provide that to you.

Ms Martel: All right. The reason I ask that question—it may be very insignificant; it may be fairly

important—is that if I read it correctly, that will draw down on the nursing and personal care envelope, won't it? You will be making a payment for supplies that, across the industry, might otherwise be used to hire personnel. Is that correct?

Hon Mr Clement: Well, the payment was being made in any event, so I guess the answer would be no.

Ms Martel: But it was being made under accommodation budget, if I understand this correctly, and now you're saying to facilities that it has to be reported and paid out of their nursing and personal care budget.

Ms Kardos Burton: We're allowing them to do that, yes.

Ms Martel: So my question is, this draws down, then, on the nursing and personal care budget, in the sense that this is money that might otherwise have gone to hire staff. Am I correct?

Ms Kardos Burton: Certainly in terms of staffing, the medical directors and the increases to that contribute to the nursing and personal care of individuals. Significant amounts of staffing have still been put into the nursing and personal care budget as it is. We will get you—

Hon Mr Clement: The most accurate answer to what you're saying is yes and no, in the sense that there is more money being provided for nursing and personal care regardless of how you characterize that particular money. Secondly, before and after we were paying for that; it was in the accommodation budget rather than the nursing and personal care budget, but in essence the public was paying for that. I think that's the most accurate way to answer that question.

Ms Martel: But the public pays for it a second way. If I read the letter correctly, it also says there will be no corresponding decrease in funding for the "other accommodation" envelope as a result. So you are telling facilities to shift that cost to nursing and personal care for the reasons you've outlined. I consider that that will draw down on their ability to do something else. At the same time, they still will be receiving funding under the accommodation envelope for the same amount as previously. Am I correct in that? I would have thought that if you were shifting, the facilities would have seen a corresponding decrease in the "other accommodation" envelope for the exact same value that you're now applying to the nursing and personal care.

Ms Kardos Burton: Are you saying that because the amount of money is no longer in the accommodation envelope—I want to make sure I understand this—and facilities are taking that out of nursing and personal care, that we have less money devoted to staffing? Is that what you're saying?

Ms Martel: On the first case. Now my second—because the letter says two things, that there's going to be a shift of this to nursing and personal care, but it also says that despite the shift, there will be no corresponding decrease in funding for the "other accommodation" envelope. I read that to mean that what the facility got previously to assist in some of these costs they will still get in their "other accommodation." That's correct?

Ms Kardos Burton: Yes.

Ms Martel: OK. What I'm concerned about, then, is this. Why would there not be a corresponding decrease in the "other accommodation" to reflect that change?

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Ms Kardos Burton: There will be increased accommodation for facility operators, because they in fact are charging the residents in terms of getting an increased amount of money from the residents. So there's no decrease in the accommodation funding.

Ms Martel: Yes, and they're also continuing to receive money from the ministry? I assume you would have covered some of the costs of supplies previously. Yes? No?

The Chair: Just under two minutes, Ms Martel.

Ms Kardos Burton: The cost of incontinence was in the accommodation budget, probably.

Ms Martel: And what was the ministry's contribution to that? Anything?

Ms Kardos Burton: The ministry's contribution was there. The amount we give in terms of accommodation, whatever it was, we can certainly get.

Ms Martel: OK. Maybe you don't have the letter and you need to see the letter again.

Ms Kardos Burton: That's true, I don't.

Ms Martel: Well, why don't I share that with you too?

Hon Mr Clement: I want to assure you that as a result of these changes, there is more money going to nursing and personal care. More hirings will take place. The industry has told us that there are 2,400 hirings that they expect to take place.

The take-home message you should have in your head—not that I would ever dictate what that is—should be that there is more money going into personal and nursing care and it means more hirings and more service.

Ms Martel: I have some questions about the numbers in terms of the 2,400. I gather that was arrived at with the long-term care industry; that was a figure they estimated could be arrived at with an infusion of $100 million?

Ms Kardos Burton: Yes. That's 3.9 people per 100 residents.

Ms Martel: Can you tell me what the current staffing is in facilities?

The Chair: Ms Martel, at this point, for this portion of the estimates your time is used up. Thank you, Ms Kardos Burton.

We now turn to the minister, who has 30 minutes to respond to the comments of the opposition party and the third party.

Hon Mr Clement: Thank you for the opportunity, Chair. I again thank members of the panel as we commence our detailed review of our budget.

I wanted to talk a little bit about some of the specific issues, but the overarching issue in terms of our priorities should be top of mind. Once again, we have seven key priorities in the Ministry of Health and Long-Term Care area. They are: first, universality and accessibility; second, the support of the public funding and sustain-

ability of the health system; third, the accountability and satisfaction we get from patients and consumers of health services; fourth, an increased number of health professionals; fifth, improved access to diagnosis and treatment; sixth, reduced waiting lists; and seventh, health protection and prevention and promotion.

As I said earlier, these were topics that were raised by the public themselves through our health care consultation. I had an opportunity to connect these seven priorities in my recent activities in Alberta at the health ministers' meeting. I would like to talk a little bit about that, again to have it on the record before coming to the specific issues that were raised.

First, with respect to the health ministers' conference, I can report to you that it was quite productive. There's a lot of collaboration among the federal, provincial and territorial colleagues. In terms of Ontario's priority for performance accountability, we cemented new initiatives on drug approvals, health status reporting and patient safety. I'm pleased to report that we made progress in establishing a single, common drug review that will streamline drug assessment and drug plan listing processes across the country.

Our own record on drug coverage has been very strong. The benefit plan of the ODB covers the cost of over 3,200 prescription drugs, with over 1,360 new drugs added to the formulary since 1995. We've had a 100% increase in the annual funding for drug programs since 1995-96, from $1 billion to $2 billion, and we're increasing the accountability.

You should know, and I'm sure opposition members as well as government members will be pleased to know, that we'll be issuing on September 30 or thereabouts our first report on indicators of health status, health outcomes and quality health care services that will be across all the Canadian jurisdictions. This is a national initiative. We'll be reporting on waiting times for cardiac surgery, access to routine health services and incidence rates for diseases. So that's coming out around September 30 across every single province and territory.

We also talked about patient safety. This is a topic that will become increasingly central to the delivery of quality health programs and accountability. We've got medical errors in our system, just like every system has. They probably occur every week, if not every day, with greater or lesser consequences, depending upon how bad the error was. It's a critical issue for providers, for administrators, and of course for the patients themselves, for family members and other members of the public.

As health ministers, we're committed to further work in this area. We've got two new innovative partnerships right here in Ontario to enhance the safety of patients. One is a partnership with the Ontario Hospital Association to develop a program to enhance patient safety in hospitals and the other is a partnership with the Institute for Safe Medication Practices to create something called the Safe Medication Support Service. These, together, will help us empower our thousands of skilled health care professionals, to give them the tools and the supports that they need to enhance the quality of care.

We also talked about the future in the wake of Romanow coming out in the next couple of months, probably around mid-November. Obviously, we've got to ensure that whatever we do also promotes healthy living. I delivered a report on strategies to work on healthy living, emphasizing nutrition, physical activity, healthy weights. We are all aware that the incidence of obesity amongst our children is off the Richter scale, that we are failing as a society to generate healthy activity amongst all of our children's population. Some are doing very well but others are not doing well at all. It's a concern for all of us, quite frankly, as parents as well as public policy advocates and administrators.

So we're looking at ways to enter this strategy on a pan-Canadian front, working with the federal government. We want to reduce the risk factors associated with diabetes, cancer and cardiovascular-respiratory diseases and, of course, the burdens they place on individual families as well as on our health care system. So you'll be hearing more about that front.

Let me talk a little bit about Romanow and other reports, like the Kirby committee report, as well. There was general consensus that there is innovation already occurring in the health care system. Federal Health Minister Anne McLellan was quick to concede and to celebrate the innovation that is currently going on in the health care system. She saw that as a positive trend. She also indicated that she wished to work with the provincial and territorial health ministers together, both before and after the official delivery of the Romanow report, on of course implementing as much as we possibly can in terms of the recommendations.

There was an understanding by her, when pressed, that innovation costs money; that we can all talk about innovation, but sometimes one has to make an investment in innovation in order to achieve the better outcomes that we want out of our health care system. She conceded the point that, factually, right now the federal government finances 14 cents out of every dollar spent in publicly funded health care and that that number, of course, is a topic of conversation amongst her caucus and cabinet colleagues. So we'll be working together on that.

Let me just talk a little bit about some of the issues that were raised. Certainly I want to put on the table here our absolute, steadfast commitment to primary care reform. It is a reform that will be, shall be, multidisciplinary. It will be a system that is focused on increased access by patients to primary care providers, including physicians but not only physicians.

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From my perspective, the issue right now, as was posed by one of the members, is, what's new about the system now? There's lots new about the system now. Even if it is not as interdisciplinary as we would like at the present, it is already adding hours of service and availability, once you're a part of the family health network. It rewards practitioners to incorporate wellness

and preventive care and multidisciplinary practices to their practices. Therefore, I think that is actually quite revolutionary. It is far and away different from fee for service and some of the distorted incentives that are found within the fee-for-service model. If you ask me what has changed, my answer is that a lot has changed already.

There is no question that the supply of physicians and nurses is a national and probably a worldwide challenge in most advanced jurisdictions, and indeed we are learning about the challenges in LDCs as well. But in advanced countries, advanced economically in terms of having a GDP per capita close to what we have in Ontario and Canada, it is a challenge.

I'm absolutely convinced that the northern medical school and the southwest and south-central initiatives and campuses will be part of that solution. Were it possible to wave the magic wand and to have these facilities up and running tomorrow, we would all be in favour of that. It is taking some time but I believe it is time well spent to create the programs that will be sustainable and be successful. I have absolutely no doubt that for the north and south-central and southwest these programs will mean greater retention and recruitment opportunities for physicians.

In terms of our nursing priorities, the funding is there. There has been a commitment by this government over the last four years for $375 million per year of funding of nursing positions, which has funded up to 12,000 new positions in the nursing profession.

The good news is that I am told applications to the nursing schools in our province have increased steadily. In one year, I believe it was last year, it increased by 20%, which indicates an interest in the nursing profession, a conclusion by prospective applicants that there is a future in Ontario to be a nurse and to practise here in Ontario. Yes, there are some nurses who choose greener pastures, as they define it. There are many nurses who after having made that choice actually make another choice and return to the profession in Ontario. We are finding examples of that as well.

I was concerned by some of the terminology that was used in the discussion about increased accessibility to MRIs and CT scans. I want to put on the record that individuals who require medically necessary services will not be paying for the use of any MRI or CT scanner in the province of Ontario. You will use your health card, not your Amex card, for those services. Indeed, none of the standards or obligations or payment structures that currently are in place in Ontario will change with any initiatives that we have planned. So what is available now will be available later. What is not available now, because it is not a medically necessary service as determined by a physician, will not be available later as part of our OHIP plan. But just as now there are individuals who pay for those services, they will be paid as well under any changes we make. That is a long way of saying there is no change in the fee structure or our expectations of what is accessible, and universally so, in our health insurance plan.

A member asked about multi-year funding for hospitals. I can assure you that we are initiating discussions with the hospital sector. That was announced as part of the throne speech and part of the budget planning process. Of course, we are in-year already in our budget for 2002-03, but it is on line and on track for next year, and that was always the intention in the plan. It does take some time to move into a multi-year funding model, and the hospitals are prepared to work with us in that regard.

I want to jump to a concern that Mrs McLeod had in terms of the northern health travel grant. We have determined the most accurate answer to your question. The northern health travel grant allocation is found in two different parts of the budget. One part is found on page 71 of your notes, as I understand it, in the integrated health services budget; there is a $6-million allocation there. There is a $5-million increase attributable to the OHIP allocation found on page 86 that makes up the difference.

Mrs McLeod: Is that a shift in funding, may I ask you? Have you shifted what was expended under the integrated health budget line on page 71 last year? Have you shifted a portion of that into the OHIP budget this year to therefore explain why it's back to—

Hon Mr Clement: I'll check on that exact question of why that is. My understanding is that this was a requirement in how we account for our money that was required by the Management Board Secretariat. The money is there but found in two different accounts.

Mrs McLeod: I'm actually looking to see where the increase over last year is, reflected in this year's estimates, so if you can get back to me with that.

Hon Mr Clement: Sure.

Mrs McLeod: Because if $5 million was in OHIP last year, it doesn't help to answer my question.

Hon Mr Clement: No. I would say that if there was $11 million last year, there is $11 million this year, but it is found in two separate accounts. That is my understanding. I'll double-check on that. There is no diminution of money available for the northern health travel grant process.

We talked a little bit about nurse practitioners and IMGs in our discussions already this morning. I can tell you that we have made progress to date, as I indicated to you. I believe the Premier and I and indeed all members of our caucus, if I can be so bold as to speak for them, want to see even more progress. We've made a start on it. But it is not acceptable to have skilled, capable, competent individuals in our society who, for reasons that are not sustainable, are not part of our health care system if they so choose to be part of it. I think we all have constituents who fit into that category. It is not acceptable. If the question is, can we work with the certification bodies to bring the certification process into the 21st century, the answer is, absolutely yes, it is happening. I will have more to report on that later on in the parliamentary session.

In terms of nurse practitioners, I want to reiterate the funding commitment of this government to double the funding of nurse practitioners in the province of Ontario. That's a budget commitment. It will happen. Details will be forthcoming. Details will be soon forthcoming. I'm sure we will all be gratified when the details will be available.

Mrs McLeod: The sooner the better.

Hon Mr Clement: I'm looking forward to that day too, believe me.

I'm sure the LTC issues were canvassed already, so I will leave it up to further questions, if there are any on that.

One final issue that was raised by Ms Martel, just on Sudbury Regional: I want her to know that I'm aware, even though I have not seen the final report, of the circumstances surrounding the operational review. I'm aware that there is some anxiety in the community, as always occurs when there is an operational review, although the operational review announcement was greeted, I believe, with a certain amount of relief and hopefulness in the community that we could finally get to the end of a very difficult time for Sudbury Regional Hospital. I, no more than her, am happy to see standstill in the capital improvements on that hospital. But we felt and the hospital felt it would be not prudent to proceed until we had a game plan via the operational review.

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It has been a very difficult and complicated process. I have lots of issues on my plate. This is one of the more complicated ones. Her understanding of that—and she does understand it, just by virtue of the questions that she asked. I think, Ms Martel, if I can address you directly, I appreciate how the individual MPPs in the area have been understanding and wanted to play a positive role in getting to a solution. So I will take your comments today under advisement. They are serious comments that were seriously provided and certainly I would be among the top of the list of people that would like to see a successful resolution to this issue as quickly as possible.

How much time do I have, Chair?

The Chair: We're looking at approximately nine minutes.

Hon Mr Clement: Let me talk a little bit about the way that we can proceed with our health care partners in place. As I mentioned earlier, there was considerable amount of discussion at the health ministers' meeting about the appropriate role of the federal government as our partner in this regard. I think it's safe to say and I can report to you that the health minister for Canada understood that with the Romanow report there would have to be a further investment by the federal government when it comes to delivering uniformly, across the board, quality health services. There was also an understanding that Ontario certainly is the leader in the delivery of services across a number of different indices. We had a little bit of a chat already this morning about home care and community care. There is no doubt in my mind that we are in the upper echelon of the type of funding that we offer and the extensiveness of that funding, for example.

There was also an understanding that we are the leaders in primary care reform in the sense that we are a jurisdiction that has the full agreement of the medical association and the family physicians' association to move forward on primary care reform, that it is proceeding as individual medical practices are signing up for the family health network. Although I concede the point that it is not as quick as we'd all like around this table, the fact of the matter is that we had no road map of another province from which to draw experience. We're actually the road map. People are looking to us because we are ahead of everyone else when it comes to having expanded primary care available through these types of networks. So there is momentum; there is progress.

Dr Wilson reported yesterday—she is the head of the Ontario Family Health Network's organization—over 700 consultations with individual family physicians who are interested in crunching the numbers and going to the next step of formal negotiations to sign the contract and to move ahead. That, I think, is good news for the system, that we are getting the interest from family physicians, who are the ones on the front lines, along with other medical professionals who are anxious to participate as soon as possible with this new type of family care.

I didn't have an opportunity in my opening remarks to go through something that is also a signal success, in my estimation, which is Telehealth Ontario. At this time last year, Telehealth was not a province-wide advice line that was available. Now it's province-wide. I can report to you that we average around 3,800 calls a day on Telehealth, but sometimes on holidays and weekends it reaches as high as 5,000 calls a day, which is way higher than our expectations of the use of the line. So it's a good success story which not only deals with tending to triaging, giving advice on whether a person should call the doctor immediately or after X number of hours or go immediately to the ER wing, but it's also a great tool for wellness and prevention strategies because the kinds of questions that are raised in Telehealth might lead to advice on diet as well as other strategies to keep well and so therefore is part of our front line on that and has been, I believe, a great success.

The initial statistics I've seen indicate that there is also some evidence that it diverts a certain percentage of the callers away from the emergency room. We are starting to get evidence of that indication as well, which is certainly one of the key purposes of having the Telehealth line available, that if there is a way to get quality medical advice without going to the ER, to leave the ER available for more acute cases, then that's certainly the type of change in the system that we would like to see.

Chair, I think I'll leave it at that and only say that it's very clear that the provision of quality, accessible health care has been a priority for us as a government over the past year but also throughout the seven budgets that we have had the responsibility to provide to the people of

Ontario. An $8-billion increase in health care spending is an indication of that. I'd go on the record to say that if money were the only thing preventing us from having the best health care that we can imagine, we would have had it solved by now. As I think all around this table would concede perhaps in quieter moments, money can help, money is part of the solution, but it's not the only solution. We need accountability in the system, we need to be innovative in how we deliver this kind of health care, and that is part of our role and responsibility as well: to provide the best possible care that is going to be sustainable in the future.

My final comment, would be that certainly, as we look to the future, we know that coming down the track is a huge demographic shift in our society. As baby boomers are within 10 years or 15 years of retirement, that is a huge shift from the workforce to retirement age. We have to start planning now. We cannot wait for that day to transpire without a plan in place for the provision of quality and accessible health care delivery as those demands will inevitably increase. That is what we're doing now, that is part of the innovations that we have started, and I believe they will stand the society in good stead in the future.

The Chair: Thank you, Minister. That leaves about three and a half minutes that the government caucus would like to make use of. I think that's appropriate. Mr O'Toole and then Mr Mazzilli.

Mr John O'Toole (Durham): Thank you, Minister, for elaborating on the vision of health care. I very quickly would just say that the terms you used are most impressive. In fact, I respect that you are that type that will follow through on innovation and accountability, and it can be exemplified in a couple of things you've said. Specifically, the drug approval process is something—I know we've been trying to get, certainly in our caucus, a more simplified process for drug approvals and I'm pleased that, with your leadership, it's now available to all Canadians. The whole idea of a report card is the accountability mechanism that you've been really a champion of, and patient safety. I'm very happy to say, as your parliamentary assistant, it's been a privilege to work and be given some challenge in terms of the primary care initiatives that you've taken, the Telehealth and the smart systems for health.

Because we have a very informed and interested caucus, perhaps other members would have some comments. I just thank you for your leadership.

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Mr Frank Mazzilli (London-Fanshawe): Minister, I just want to go over the long-term-care issue and the increases. I think there are figures floated all over the place. The $8 that was originally supposed to be one year—we heard from an assistant minister that it was 61,000 people, so simple math would be about $50 million that was spread over three years. What have the taxpayers put in—$100 million in one year?

Hon Mr Clement: In one year. Actually, the number would be $200 million on all LTC programs, but for the purposes of the type of question you're asking, it would be an additional $100 million, that's right.

Mr Mazzilli: And the industry is looking for some $700 million or $750 million over three years, but obviously, with the copayments, that commitment has been made for three years now. Therefore, any future copayments have been spoken for over a period of three years.

Hon Mr Clement: Yes, that's our plan for the three-year period; you're quite correct.

Mr Mazzilli: I just wanted Mr Gerretsen to know that.

Mr O'Toole: Mr Chair, one final comment: I just want to put on the record that in respect to your work on this issue, I want to quote the Toronto Star article, which I think is not often complimentary. It says, "The Ontario health care budget—which has reached a staggering $25 billion annually—is by far the richest in Canada, offering the widest range of services to the most people." That's the August 31 edition of the Toronto Star. So I think you should take some solace—

Hon Mr Clement: I've got that framed on my wall, actually.

Mr O'Toole: It's in my householder.

The Chair: We now turn to the official opposition party.

Mrs Pupatello: I have many questions I'd like to put to the minister.

The Chair: Just for the benefit of everyone, these are 20-minute rounds to each of the parties, though they need not be adversarial. It is basically a question-and-answer session moderated by the people themselves, and I'll intervene as appropriate. But again, the point here is to get at the public interest around the estimates. Mrs Pupatello, I'll ask you now to commence your 20 minutes.

Mrs Pupatello: Minister, I'd like to know if the OHIP department of your ministry can give me the total amount spent in OHIP costs out of country.

Hon Mr Clement: Just so I understand the question as we're getting the expert on that, that is for Ontario residents who bill OHIP for out-of-country medical procedures in the year? Is that the question?

Mrs Pupatello: Yes. While that person is making their way to the table for those out-of-country costs, I'd like to know if there's also a breakdown available of what those out-of-country costs are for. For example, I'd like to know the total CT scan cost for patients from the Kenora-Rainy River area to be sent to Manitoba. I'd like to know the total cost of all angioplasty done at Beaumont Hospital in Detroit. I would like that kind of specificity in the data provided.

The Chair: I'm advised by the clerk for the purposes I guess of Hansard and so forth that we need staff coming forward to sit in one of the witness seats. So perhaps we could make an arrangement for a seat there that people who come up could use. And of course, to do what you've already been doing, which is to introduce yourselves.

Hon Mr Clement: This is known affectionately as the lions' den. This is David McCutcheon, who is the assistant deputy minister for health services.

Dr David McCutcheon: What I'll have to do—and thank you for the question—is come back to you with the specifics and the detail of that. I will get that during the break and come back to you with the specifics.

Are there other questions you would like to ask regarding—

Mrs Pupatello: Yes. Is there someone in your office, then, who does a regular review of where out-of-country expenses are coming from in terms of invoices for your department to pay?

Dr McCutcheon: Yes.

Mrs Pupatello: Do they review and see that you suddenly have a number of them coming for cancer care, so that at some point you were sending many to Buffalo, for example, and then you would start to review that and then something would happen within your department to flag or red-flag some department within the ministry? Likewise, did somebody flag the cost to OHIP for out-of-country when you were paying the Manitoba bills for CT scans from the Kenora area?

Dr McCutcheon: Yes, we continue to review these on an ongoing basis and do a review. We would look at new technologies, for example, that are available maybe initially south of the border and then would look at the medical necessity of those being provided in Canada.

Mrs Pupatello: Would your department have made the minister aware of the $750,000 spent in Manitoba in the last year for CT scans?

Dr McCutcheon: We would report these various items, but the specifics I need to get for you.

Mrs Pupatello: Could the minister then explain why we haven't had an announcement for the CT scan to be purchased by Lake of the Woods hospital in Kenora yet, even though they have fundraised in the community for it? You're spending much more than the costs in Kenora to have the services provided locally, saving enormous cost to the individuals themselves for travel etc. As you know, the Ministry of Health budget does not cover all of the expenses for people who have to travel to Manitoba. What could possibly take as long to understand that you'd save money out of that page in the estimates book if we had a CT scan right there at that Lake of the Woods hospital?

Hon Mr Clement: I can tell you a couple of things. First of all, I can report that certainly individual meetings have taken place with ministry officials related to that very issue. I believe that the last meetings took place on July 30 and 31 of this year. I will say this generically, if I may just for a second indicate to you, that any proposal for the addition of medical services has to be accompanied by a business plan, a business case, if I can put it that way, indicating not only that the capital cost is looked after but that there is a means by which the deliverer, in this case a hospital, has the capacity in its budget to handle the operating costs in a sustainable manner as part of its overall budget.

Mrs Pupatello: Can you just explain that further? I'm assuming that if you announce that they could go ahead and purchase with their capital money the actual CT, you would then be funding the operating costs that would go to that hospital budget for that purpose. Is that not what would happen?

Hon Mr Clement: That is true, but we have to have confidence that the taxpayer dollars will be allocated for that purpose in a way that meets our expectations.

Mrs Pupatello: Do you not have an audit process in your ministry that you know where each hospital spends the money that you give it for whatever express purpose?

Hon Mr Clement: Yes, we do.

Mrs Pupatello: So is there some history with this hospital that you don't have confidence in their spending that CT operating money on CT scans?

Hon Mr Clement: The history, as you may be aware, is that we had some concerns about their ability to keep their budget balanced and to deliver. Obviously that is part of our expectation. In this case that is why the discussions took a bit of a more complicated turn.

Mrs Pupatello: Minister, if you used a hospital running a deficit as an excuse not to announce a program, you wouldn't be able to do anything with 70% of the hospitals in Ontario today. That answer is just completely unacceptable. I would urge the minister to review that. The people in that area have waited for some time, and for a fairly small-populated region they have fundraised a tremendous amount of money for this piece of equipment. I think it behooves the minister to make that approval and make it quickly, especially in light of the fact that the OHIP department is spending more taxpayers' money to send people to Manitoba for the same service. I would urge the minister to review that.

Hon Mr Clement: Can I then say in response, because I'm assuming there was a question in there somewhere, that I do want to put on the record that you were asking me about the historical concerns that the ministry had about this particular proposal. That is what I answered. I can update you and indicate that the hospital has agreed to a revised proposal based on a sustainable operating plan, and we are in the midst of, in an expedited manner, reviewing that.

Mrs Pupatello: Do you have a timetable for that, Minister?

Hon Mr Clement: They're doing their final preparations so I have to wait for them to actually submit the proposal. Once that happens, certainly we will move as quickly as possible.

Mrs Pupatello: Some time last year, Minister, in fact you had visits with several cardiologists in the Windsor area, and for various purposes, I may add. In one of these visits you had a significant discussion about bringing an angioplasty program to the Windsor area. I think you enjoyed visiting these people in their homes—

Hon Mr Clement: I was so successful in the latter initiative that you're referencing.

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Mrs Pupatello: Nonetheless, I think it gives you more opportunity to focus on these important services of government, specifically having angioplasty available in the Windsor area.

I provided the minister with some information about the cost, again, of sending our patients to Detroit for these surgeries. Most of these, of course—or, I should say, all—are done on an emergency basis because the patients can't get to London, nor is there the room in London, so these patients are being whisked through the tunnel, halting traffic, I must say, with our congested border crossings, stopping all traffic to get the ambulance through the tunnel and to the hospital for emergency surgery in Michigan. The cost associated with this cardiac surgery in Michigan is tremendous—much more than if the program in fact were offered in Windsor, where the lion's share of the ability to provide the service already exists, but for a couple of pieces of the pie, to offer angioplasty.

It's not uncommon that this would be offered in a community hospital. Minister, again last year, for a variety of reasons, you made an announcement in the Scarborough area to offer these cardiac services in Scarborough in a community hospital. Could you explain why you haven't made that announcement for Windsor, even though the Cardiac Care Network of Ontario has recommended that you do so?

Hon Mr Clement: There are a bunch of facts that have to be clarified as a result of your statement. First, the Cardiac Care Network is in agreement with me that a pilot project to review stand-alone angioplasty services is recommended. That pilot project is taking place in Scarborough. I met with the Cardiac Care Network two weeks ago. They have indicated that the progress on assessing the safety of the stand-alone angioplasty clinic is progressing quite well.

But to say that it is not uncommon in the system to have a stand-alone angioplasty—it's very uncommon in the system to have a stand-alone angioplasty service, for health and safety reasons. We have one in Scarborough to assess the health implications and health risks of having stand-alone angioplasty. When that report is available to me—that is to say, when I'm convinced that the health issues of a stand-alone angioplasty service are manageable—I have indicated that there is nothing stopping the Windsor area from making an approach at that time. It is not the case, as some have argued, that because I as minister approved a stand-alone angioplasty pilot project in Scarborough, there will never be a stand-alone angioplasty service in Windsor; it is inaccurate and incorrect.

That is the proper characterization of the status of things.

Mrs Pupatello: Minister, I don't believe that Cardiac Care Network report suggested to you that you not run that pilot project in Windsor. In fact, I think the contrary is true. I think they suggested that Windsor would be a good site, and that you had conversations with the cardiologists there, suggesting that it was a good site. I also understand, through various discussions with your staff, that it was well on its way to being announced. We just fail to understand why you haven't announced it.

Hon Mr Clement: You're flat-out wrong.

Mrs Pupatello: Your executive assistant confirmed for me as well that it was still on track, and my greatest concern—

Hon Mr Clement: It is on track. We have to make sure we're not killing people in the process.

Mrs Pupatello: Minister, the problem we have is timing. You're very selective about where you're choosing to make these announcements.

Let me just confirm with these two examples that it's the ministry's responsibility to permit new services like this in regions. So I would say that the ministry has to give approval for new programs to be available in different regions, like the angioplasty service in Windsor. You go through various machinations to determine that a service can exist, that you'll fund the program etc. The ministry gives permission.

I'd like to know why the minister doesn't give permission to remove services from communities.

Hon Mr Clement: "Doesn't give permission to remove services from communities."

Mrs Pupatello: So, for example, the London Health Sciences Centre made a list of some 60 services in this past year that it would be eliminating from their docket of what they would offer through London Health Sciences Centre. Recently, in this last month, Toronto General decided that they would no longer offer the hyperbaric chamber for the next 15 months.

These kinds of decisions made by local boards to remove services from their community: why did they not need your approval, considering you give approval that they should exist in the first place?

Hon Mr Clement: I would characterize it in a slightly different way. I think in both cases the role of the ministry and the minister as accountable would be to ensure that health and safety is protected. So in order to approve a new program, one has to look at the health and safety implications of that. In order for a program to not be made available, the Ministry of Health and Long-Term Care in fact does have a role to ensure that the health and safety of Ontarians is not compromised. So in my mind, there's no dissonance of point of view on that.

Mrs Pupatello: So, Minister, are you then suggesting by that statement that you have agreed with all of the service cuts through hospital board decisions that have been made in Ontario?

Hon Mr Clement: I'm not sure I understand the implications of your question. Because certainly, you've made reference to the Toronto situation with the hyperbolic chamber, as I understand it—hyper—

Mrs Pupatello: Hyperbaric.

Hon Mr Clement: It might be hyperbolic as well, but that's a different issue. Hyperbaric chamber—certainly, this ministry is in the process of assessing the implications. So to suggest that a decision has been made

is not exactly accurate. Perhaps I can leave it to Dr McCutcheon.

The Chair: The hyperbolic chamber is at the bottom of the Legislature.

Hon Mr Clement: That's right. I don't know why my mind just automatically careened to that, Chair. Thank you for understanding my psyche.

Mrs Pupatello: Just on that, Minister, can I assume by your statement then that the decision by the Toronto Hospital to remove those services of the hyperbaric chamber for the next 15 months is under review and not a final decision, as far as your ministry is concerned?

Hon Mr Clement: Is it Allison Stuart who has the most information on that? Allison Stuart, come on down. She is the director of hospital programs in the health care programs division. I'm getting better at the titles now.

You can give us a status report on the hyperbaric chamber.

Ms Allison Stuart: The hyperbaric chamber is being put on hold for a period of time because of the reconstruction that's going on at UHN. It's not a decision based on an operational perspective. It's because of the capital redevelopment at UHN and the relocation that will be required as the hyperbaric chamber moves and also as emergency departments have moved. So that's the reason for this initiative in the first place.

There have been arrangements made for the patients who are using the hyperbaric chamber for emergency purposes. Hamilton has agreed to follow up on those. Although there was communication earlier with some of the major users, meaning fire, police etc, there is a continuing dialogue going on there, because most recently there have been some concerns raised by these first responders. So those discussions are underway now.

Mrs Pupatello: Those concerns that were raised to you just recently then, did they include the fact that other centres were not going to be able to accommodate the needs that were provided by the Toronto site?

Ms Stuart: The concerns expressed by first responders is really around the emergency procedures that go on in a hyperbaric chamber, and those emergency procedures will be taken care of through an agreement with the hyperbaric chamber in Hamilton.

Mrs Pupatello: I might say to the minister that in the health department at large, it doesn't have the luxury that DaimlerChrysler has, for example, to shut down the line for two weeks and change the line to begin to produce a new car. The problem with health restructuring worldwide is that you have to continue to provide the services while you make the changes. I don't believe that construction or restructuring is an excuse to shut the service down for 15 months, in this case, of the hyperbaric chamber. Something has to be brought to bear in that decision.

I'm going to assume from the comments then that, because you're responsible, Minister, for the health and safety of Ontario residents, that decision is not final and that in fact it may be halted. The information we have is that the professionals are suggesting to the ministry that they will not be able to get services elsewhere.

Hon Mr Clement: Certainly, if you are apprised of information of which we are unaware, I'd encourage you to bring it forward, and certainly we'll take a look at it.

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Mrs Pupatello: I'd like to review the drug programs on page 90. I have a question regarding drug programs. Page 90 itemizes the amount and expense of drug coverage.

The Chair: Two minutes, Mrs Pupatello.

Mrs Pupatello: The pharmacists of Ontario have provided annually a number of recommendations.

Hon Mr Clement: Sorry, who did?

Mrs Pupatello: The pharmacists of Ontario have provided annually a number of ways to reduce costs of drugs, for example, the use of the trial size prescription and various efficiencies in the system. The minister himself has suggested that there have been annual increases that can be controlled. We are seeing that there is going to be an additional increase that's suggested to be because of increased use. One of those you suggested was Visudyne.

I'd like to know what amount has been set aside for the coverage of Visudyne as the new drug, and I'd like to know what changes in that amount are due to the fact that you have limited the coverage of Visudyne to those who have lost 50% of their vision. For example, if you've lost 25% of your vision, you haven't lost enough vision to get Visudyne covered. It just seems like an incredible policy to me, because it's a degenerative disease of the eye and you know that eventually they're going to get to 50%. I can't imagine that this minister would have set that kind of regulation in the coverage of Visudyne.

You had a great fanfare to announce coverage. Then we found you wouldn't backdate it for patients who had need of it and had spent their life savings on it, and when you instituted it, you allowed it only for people who have already been half-blinded.

Hon Mr Clement: I'm sure Dave McCutcheon, assistant deputy minister, health services division, might give you some details. But I would say generally that we do rely on clinical advice, on medical advice in the application of these new medications and procedures; that is to say, these decisions are not made in the abstract. That is how they are made; they are made based on clinical advice. With that, if I can leave it to the assistant deputy minister.

Mrs McLeod: On a point of information, Mr Chair: Perhaps the minister's deputy can provide the information, but if not, I would like to be made aware of the specific medical advice that suggests that before Visudyne should be covered there needs to be a specific loss of vision incurred.

The Chair: We are out of time for the intervention. Is there agreement that that information is forthcoming?

Hon Mr Clement: We'll take it under advisement at this point.

The Chair: OK. I now turn to the third party.

Ms Martel: I would like to turn to the nursing—

Mrs Pupatello: On a point of order, Mr Chair: I'm sorry to interrupt. Does taking it under advisement mean that information will be tabled?

The Chair: Yes. Under the process on this committee, we work on an agreement basis. If the ministry agrees to provide it, they provide it. If they don't, the researcher contacts the ministry and it's subsequently provided.

Now I will commence the time for Ms Martel.

Ms Martel: Thanks, Mr Chair. I would like to turn to the nursing announcement for the long-term-care facilities. I want to begin by asking, what is the Ministry of Health budget now for the nursing and personal care envelope for long-term-care facilities?

Hon Mr Clement: I did have that information right in front of me until a couple of minutes ago. The new per diem, as of August 1, is $59.62.

Ms Martel: You've got $1.7 billion in terms of the estimates for all of long-term-care facilities. Can you give me the breakdown of the $1.7 billion? What's the global breakdown?

Hon Mr Clement: So you want it on the macro numbers rather than per diem numbers?

Ms Martel: Yes. Just give me the nursing and personal care envelope. That would be great.

Hon Mr Clement: That's easy to do.

Ms Martel: You don't have it?

Hon Mr Clement: I think Mary Kardos Burton is going to come up.

Ms Martel: OK. So they don't have it right now.

I would like to know, does that include the $100 million that has already been announced? I'm not sure when that was supposed to flow. I know it was announced July 31. I see there has been a change in the increase in per diem for September 1. I'm not sure how long it will take for all of that money to flow.

Hon Mr Clement: Yes. That changes the estimates, so we'll have a revised number.

Ms Martel: Then what I'd like to know, because I'm quite concerned about this issue—that is, you've made an announcement about 2,400 new RNs and personal care workers with this money. I'd like the numbers for the current staffing in long-term-care facilities before that exercise starts. So currently, before people start hiring, can the ministry table the current number of RNs in long-term-care facilities and the current number of personal care workers now in long-term-care facilities? I'm assuming most of that nursing and personal care envelope is essentially a staffing envelope. Would that be correct? I mean, the majority of that budget would be that?

Hon Mr Clement: I hope so.

Ms Martel: I'm getting to why I'm going to ask that question.

Hon Mr Clement: Do you have those? Can you get those, Mary?

Ms Kardos Burton: No, we'll provide you—we don't collect those numbers on a regular basis, but we will certainly approach the associations to see what we can get. It's just the nursing numbers that you're asking about?

Ms Martel: And the personal care workers.

Ms Kardos Burton: The personal support staff, OK.

Ms Martel: I'm curious as to why you wouldn't have those numbers. I would have thought that facilities would have had to—

Ms Kardos Burton: Facilities would have them. It's just a matter of our collection of them.

Hon Mr Clement: And updating, because it constantly changes.

Ms Kardos Burton: Yes.

Ms Martel: But they have an obligation to table that, and you have an obligation to track that?

Ms Kardos Burton: Yes.

Ms Martel: How does the public become aware of those numbers? You're going to give that to us because I asked this question, but is there a mechanism that, as this money unfolds, we're going to be able to track new staff coming into facilities?

Hon Mr Clement: Yes, and in fact that's the case. Minister Newman and I have made it quite clear to the sector that we are watching very closely in terms of their hiring practices as a result of the infusion of new money and that we expect to have fairly comprehensive reports on the progress.

Ms Martel: Are you providing them with some guidelines around the hiring? I ask this question for this reason: about 1996, your colleague Mr Wilson was in a similar exercise and made announcements about new numbers of nurses in long-term-care facilities. What happened in our community was that a good portion of the money that was allocated to at least two of the facilities actually went to pay increases in WSIB premiums and in disability benefits versus actual new hires of staff. So I would like to know what conditions you are placing on this funding to ensure that in fact it's going to be used exactly to hire new staff, either nurses or personal care workers.

Ms Kardos Burton: First of all, the long-term-care sector, as you probably know, has fairly intrusive reporting into the ministry; there are a lot of reports and forms that are required. Through our regional offices, we will be working with the long-term-care facilities in terms of how they're hiring and who they're hiring. We'll have a reporting mechanism.

I guess the one comment I would make is on the availability of staff. Certainly our goal will be to ensure that those staff are in fact hired. But it wouldn't be fair if I didn't say, regarding the availability of personal support workers, we know we have to train personal support workers—and we also know that nursing in terms of the attractiveness of the jobs elsewhere. So we will do what we can from a human-resource-strategy point of view, but there's no question that we will get that information, and those are the conditions.

We'll have to ensure that the facilities are doing everything possible and also that we are working with and will continue to work with both long-term-care

associations. We've already been approached on human resource strategies. We've got a commitment to work with them, look at systems and look at mechanisms that are in place for that.

Ms Martel: I would encourage you, if there is not a policy in place, to actually have a policy that says that money from that envelope cannot be used for those purposes. In 1996, the facilities were not doing anything wrong; they were allowed to do that, and that was the problem.

Hon Mr Clement: If I can jump in just for a second and indicate to you that we, meaning Minister Newman and myself, are quite aware of the history and are quite motivated to ensure that the monies that are invested on behalf of society are being put to a desirable use.

Ms Martel: And can I be clear—

Hon Mr Clement: We're not getting any pushback from the industry, by the way. They acknowledge that and recognize that. I wouldn't want to leave that on the table as if this were adversarial. We've had a lot of co-operation from the industry.

Ms Martel: The 2,400 estimate, is that over a three-year period, a one-year period? What was your timeline around the 2,400 new nurses and personal care workers that were part of the announcement?

Ms Kardos Burton: I believe that was over a three-year period.

Interjection.

Ms Kardos Burton: Yes, I know it's the estimates. It was from the long-term-care association.

Ms Martel: But, to be clear, it's over a three-year period, not in—

Ms Kardos Burton: I can verify that for you.

Ms Martel: All right. That will be very useful. Just following from that, because there are going to be some changes, and changes in staffing, you've already said that there is an intrusive reporting mechanism. I assume some of that is supported by inspection staff or compliance staff as well. With this increased funding—which I am assuming is on an annual basis, the $100 million?

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Ms Kardos Burton: Yes.

Ms Martel: Are you planning to hire, then, more compliance or inspection staff?

Ms Kardos Burton: We currently have around 40 compliance staff. You know, and we're pleased to report, that for two years running we do have 100% compliance. So we're very pleased about that. We hadn't looked at an increase in staff, but what we do have in place is a compliance management review program. While we're very proud of our record in terms of 100% compliance, we also need to look at making sure that the way in which we're doing it is the most appropriate way. So we're working with our audit people in terms of looking at risk management: are there red flags that should be in place? We are looking at our compliance program. We have not got to the point of additional staffing or types of staffing. Certainly there's no reduction planned.

Ms Martel: I raise that in the context of ensuring that it's actual, real, live bodies who are hired, and if you require inspection and compliance staff to make sure that happens, then you will have to obviously shift the estimates again, because there's no change in the estimates on that line item.

Hon Mr Clement: Just to be absolutely clear, could I also mention—I don't know if you mentioned it, Mary—that the 2,400 also includes in that number some that would shift from part-time to full-time? I want to make it absolutely crystal clear that that is included in the number. That is an enhancement on availability of nursing and personal care.

Ms Martel: In line with that, there were minimum standards that were in place that were done away with—2.25 hours of hands-on care. Is the government going to be implementing, then, a regulation with respect to its expectations with respect to hands-on care?

Hon Mr Clement: My understanding is that the terms of reference for the funding itself will have some expectations that will be spelled out quite clearly.

Ms Martel: Will it be spelled out in regulation?

Ms Kardos Burton: There's no decision made on that at this point.

Ms Martel: Then I would very much encourage that. I encourage, in fact, a higher number than the 2.5. Your own study by PricewaterhouseCoopers, in making comparisons of long-term-care situations in other jurisdictions compared to Ontario, had some shocking statistics with respect to Ontario in terms of the lowest levels in that regard. I really think if you're going to make an investment you'd better be absolutely sure that's happening. The only way you're going to get there is to have a very clear regulation that becomes a compliance issue for licensing purposes. So I would very strongly encourage you to do that, and do it higher than the 2.2 that was in place before it was cancelled.

Hon Mr Clement: With respect, I know you wouldn't mean it any other way, but the report to which you refer now is dated because of the funding announcements that we have made. I just want to put that on the record.

Ms Martel: I guess it remains to be seen because it's really hard to track. If you have no minimum standard it is very hard for the public or anyone else to track what the actual hours are—right?—that are being provided.

Hon Mr Clement: I suppose my point was that it was based on funding levels which have been improved since that time.

Ms Martel: It can be improved still with a regulation.

Let me ask one other thing, because wage parity is a huge issue for RNs in this sector. Are you taking that into account in any way, shape or form with this announcement? I mean, you're losing nurses out of long-term-care facilities to move into the hospital sector because of the wage gap.

Ms Kardos Burton: That's correct.

Ms Martel: Does the announcement address that in any way? Is a portion of that money at all set aside to

achieve parity, to start to move toward parity, if that helps?

Ms Kardos Burton: It's not specifically stated as such, but certainly in terms of attracting individuals, I think facilities will be looking at that. But it's not specifically stated in terms of wage parity.

Ms Martel: Is the ministry going to leave that for facilities to decide or are you going to come to some policy that a portion of the money that's been allocated will actually be used for parity across the long-term-care sector for nurses to bring some of those wages up and to retain them in those facilities? Are you considering that?

Ms Kardos Burton: This is an area that historically has been very difficult in terms of parity within the systems. We can certainly work with the associations. We're certainly aware of the problems. I mentioned earlier that there are human resource issues as well. But historically governments generally have not said—

Hon Mr Clement: Can I say that historically we've left the negotiations of remuneration, salary, those kinds of things, up to the individual sector? For instance, it's the hospital association that has the negotiations with the Ontario Nurses' Association. Similarly, individual facilities and so on are responsible for that. I wanted to put it in that perspective, that historically it's been the case. That hasn't changed. We're aware of the challenges.

Ms Martel: The facilities would have argued before, rightly or wrongly, that they didn't have the money to accommodate that. Now there will be an infusion of cash into this nursing and personal care envelope. I'd suggest to you that you make it a strong consideration for them that they do something about that. Otherwise, the people who are trained, we're just going to lose, which will not benefit anyone in terms of continuity of care.

A couple of more questions just with respect to the long-term-care announcement: can you table with the committee how many residents would have been subsidized prior to September 1, to the fee change?

Ms Kardos Burton: In looking at the information that you asked earlier, we'll include that as part of it.

Ms Martel: I'd like that before and after, and the values from before and the value after as well, in terms of your subsidy for people who can't afford the payment.

Hon Mr Clement: Again, with the caveat that individual operators make individual decisions that could be different than the minimum standards that we expect.

Ms Martel: What will the impact be of increasing the minimum-income threshold over the next three years? What will the impact be on subsidies, or will there be an impact? I'm going back to the announcement in terms of other things that were listed that you were going to do. Another was—

Hon Mr Clement: The impact of the three-year phase-in?

Ms Martel: No. One point was increasing the minimum-income threshold for seniors in each of the next three years. Can you give me an idea of what the impact of that will be?

Ms Kardos Burton: In terms of numbers, I don't have that with me but we'll do that as well.

Ms Martel: OK.

Hon Mr Clement: In terms of the numbers of people that are subsidized? Is that the nature of the question?

Ms Martel: Yes. I'm assuming it's going to impact on the subsidy system in terms of—I would suspect it might increase subsidies. I could be wrong, but I would suspect that would be an increase in terms of expenses the government is having to cover.

Ms Kardos Burton: We will provide you with what we can, but I do want to say that they will be projections and estimates. But we will provide what we can in that area for you.

Ms Martel: Can you do it over the three years of the announcement?

Ms Kardos Burton: We'll see whether we can and see whether there are assumptions we can use to do that.

Ms Martel: OK. Two other announcements were made the same day. One was a review of the comfort allowance. Can I ask where that stands at this point? What's the status? Are there negotiations going on with—

Ms Kardos Burton: The commitment was made to review the comfort allowance. In looking at the comfort allowance, you have to do one other thing. The comfort allowance has historically been related to the amount of money that has been given to people who are collecting income assistance as well. We've already met with the Ministry of Community, Family and Children's Services, and anything that we do in terms of reviewing that would be with that ministry. So we are well aware of the commitment and we will be meeting that in terms of looking at the comfort allowance. Then we would take forward our recommendations to government.

Ms Martel: I'm assuming you're looking at increasing it. That would be my assumption from the announcement. Do you have a timeline for this?

Ms Kardos Burton: We are aware there has not been an increase to the comfort allowance in a significant period of time. Certainly the intention was to do it fairly quickly, and we are on it.

Hon Mr Clement: I can assure you that Minister Newman has indicated to me that this is one of the top issues on his radar screen. Certainly he's turning his mind to it.

Ms Martel: OK, but you can't be more specific than that in terms of—starting the new fiscal year?

Ms Kardos Burton: No, because we will make recommendations. We will certainly do the best we can as quickly as we can, but they are recommendations and certainly we're intending to do it ASAP.

Ms Martel: Those recommendations will be to the minister, so I hope, Minister, you'll be able to deal with that as soon as possible.

The final one was an announcement that there had been amendments to Ontario's bathing regulations to better meet individual needs.

Hon Mr Clement: Yes.

Ms Martel: Can you tell me what the change is?

Ms Kardos Burton: The bathing regulations: in fact I don't have the exact wording, but the intent was to ensure that there were appropriate baths provided to individuals.

Hon Mr Clement: It's a minimum expectation which can be improved upon, but there are certain minimum expectations that will be embodied in the regulations.

Ms Martel: But it has been passed already?

Hon Mr Clement: That's my understanding.

Ms Kardos Burton: Yes. It actually was for all long-term-care facilities to better meet the individual needs of residents, ensure their daily health and hygiene and ensure that care is delivered consistently. I underline "consistently" to ensure that—

Hon Mr Clement: Yes, that has been passed.

Ms Kardos Burton: Among the different types of facilities. I can read the exact words, if you wish.

Ms Martel: Does it mean three baths a week, four? What does this mean?

Hon Mr Clement: It was decided that that would create more problems than it would solve in terms of minimum standards, so we've actually thrown it back to the sector. The wording is, "The nursing staff shall ensure that proper and sufficient care of each resident's body is provided daily to safeguard the resident's health and to maintain personal hygiene." So there's a standard of care embodied in the regulation—this regulation has passed—and they will have to meet that standard of care.

Ms Martel: But the responsibility is for the RN to ensure that happens?

Hon Mr Clement: The RN is delegated that responsibility, that's right.

Ms Martel: Who had the responsibility to ensure that before? Was it the operator?

Ms Kardos Burton: Overall, the operator has some insurance, but each individual has an individual care plan. The reason that it's worded the way it is is to ensure—some people have a greater need than others. It was a conscious choice to make that wording so that people are in fact taken care of.

The Chair: Just under two minutes, Ms Martel.

Ms Martel: Mrs McLeod, is this a regulation that replaced a previous regulation? Is that what you have done?

Mrs McLeod: I believe so, yes.

Ms Martel: Could you table both for us, because—would I be correct in assuming that the previous regulation actually had a standard set? Did it say one bath or two? Is that what it actually said? Now you're replacing that with something that doesn't—

Ms Kardos Burton: With something that in fact could be for a day, if that's what the person's needs were.

Hon Mr Clement: That's right. I think it's more sweeping, quite frankly.

Ms Martel: Jeez, I disagree with you. I think we've just gone completely backwards. I'm very concerned about offloading that responsibility on to an RN in a facility. I think the owner-operator has a responsibility to ensure that there's adequate staffing to make that happen.

Hon Mr Clement: Yes, and that's still the case. That has not been retracted from this particular regulation. There is still a regulated overseeing responsibility by the owner-operator to meet the standards of care and to ensure that his or her staff have the resources available to meet the standard of care. Indeed, we had a recent case in the GTA, in Halton region, where we decided the operator was not meeting the standard of care and we acted. So we do have that power. We do have that oversight. We do have that responsibility, in conjunction with the owner-operator.

Ms Martel: But the regulation suggests that the onus, and/or if there's a penalty for non-compliance, falls on to an RN, not on to an operator.

Hon Mr Clement: That is true. In our health care system, individual providers always have a duty and standard of care which they are required to perform as members of the medical profession.

Ms Martel: Minister, the RN doesn't determine the staffing levels in a long-term-care facility. If the operator says, "We're not bringing in someone to replace you tonight," that's not her or his fault.

Hon Mr Clement: That is why in other standards, procedures and regulations we have standards of operation for the facilities which are still in place and which we used as recently as three weeks ago to divest someone of their responsibility of maintaining a facility. So we take that very seriously.

Ms Martel: If you could table both for us. And the other thing: in terms of ensuring compliance now, is there a change around how you monitor compliance with this new regulation?

Hon Mr Clement: I've just been reminded that all operators must comply with a total of 427 standards for long-term-care facilities, so those are in existence right now, if that helps you understand the range and scope—

Ms Martel: I understand that, Minister, but if that would have been the case, then we wouldn't have been lobbied, as we have been by the industry over the last year, with one of the key caveats that people can't get much more than one bath a week. Yes, they're supposed to comply, but on the ground, is that happening? Clearly, it hasn't been.

My concern is that you at least had a regulation where there was a standard in place, a numerical standard if you want to put it that way, which now you do not. I think that's going to make it even easier for operators to do less, not more. That's my concern.

Hon Mr Clement: I think that—

The Chair: Thank you, Ms Martel, and thank you, Minister. We will come back and look forward to the questions from the government party after lunch.

I gather we have an agreement, Minister, to resume approximately at 1 o'clock to allow you the extra time that you need. That's the tradition of the committee: to try to accommodate the minister rather than proceed without you.

I will ask the caucuses to remember that we need Mr Chudleigh, Mr Gerretsen and Ms Martel in committee

room 2 for a subcommittee meeting immediately during the lunch period. We'll see everyone else at precisely 1 o'clock, when we'd like to reconvene.

The committee recessed from 1204 to 1304.

The Chair: With the arrival of the government caucus, we'll now continue with the government caucus. We appreciate you've been taking that time in preparation. We will allow you now your 20 minutes with the minister.

Mr O'Toole: We'll be sharing our time as Mr Chudleigh prepares his comments and questions.

In fact, the questions from the opposition and the third party are very instructive as well. I think it's my duty to represent a broader interest but also, in a specific way, my own riding of Durham. It fits in very nicely with the discussion just before lunch. I have had a fair amount of questions on the long-term-care issue. One of the issues to address the lack of physicians in the area is the role of the nurse practitioner. It's very important in the delivery of primary care and, more importantly, in the long-term-care units. We're finding some doctors are reluctant to take that task on. It's a requirement under the regulations, as I understand it.

I am concerned too, and maybe you could respond to this: I know in the budget and other commitments you've made personally that the role of the nurse practitioner in the delivery of primary care services in Ontario is expected to expand. I'm wondering if you could perhaps just illuminate a little bit your plans in that direction. Will it affect long-term care and the doctor shortage issue?

Hon Mr Clement: Thank you for the opportunity. Thank you again, Chair, for allowing us the chance to be accountable for some of these issues. I might state for the record that Mr O'Toole, quite apart from being an excellent representative of his community, as parliamentary assistant in the Ministry of Health and Long-Term Care is looking specifically at some of our information technology issues and how best to integrate, via IT investment, better-quality health services. He's doing a lot of work in that area and I would consider him a bit of a resident expert at this particular stage.

You are quite right in the sense that the role of the nursing profession in general and certainly nurse practitioners specifically is expanding in our system. There have been certain regulatory changes pertaining to scopes of practice which have already occurred and which expand the role and the capacity of nurse practitioners, for instance, in the system.

Interestingly, this is not just an issue about nurse practitioners. If I can take it more broadly, because you mentioned long-term-care facilities, there are some exciting trends in regard to the individual roles of registered practical nurses as well as registered nurses. There are some interesting conclusions that have been drawn by the College of Nurses of Ontario about relative scopes of practice which I think will be useful in the future to meet the needs that are inevitably going to be placed in this particular sector as our society ages.

The short way of responding to your question is to say that, absolutely, there are changes in scopes of practice. There are changes in funding to the better that will enable us to expand the role of nurses and nurse practitioners in the system. Again, let me signal that more good news will be occurring as we roll out the budget commitments of this government.

Mr O'Toole: Good. Mr Chudleigh has a question.

Mr Ted Chudleigh (Halton): I have a question for you on the West Nile virus. We've had one identified case in Burlington, just south of my riding of Halton, and two suspected cases, I believe. I understand we've done a lot of work over the past year on protecting people from West Nile virus. I'm sure that over the course of the last two years we've learned some things about controlling the virus and controlling the things that spread the virus, mosquito larvae in particular. I wonder if you could tell both us and the people of Halton what is going to be happening next year as we have one more year's experience with this virus. Hopefully we'll be able to learn things from that and protect the people of Halton and, indeed, the people of Ontario more adequately.

Hon Mr Clement: Thank you for the opportunity. If I can just make one correction, I think we have five suspected cases to date in total.

Mr Chudleigh: There's three in Halton.

Hon Mr Clement: Three in Halton. I think we've got a couple in Peel.

Dr Karim Kurji: Five in Peel.

Hon Mr Clement: Five in Peel.

Dr Kurji: One in Toronto.

Hon Mr Clement: One in Toronto.

Dr Kurji: Three probable in Halton and one confirmed.

Hon Mr Clement: One confirmed and three probable. So I think we're upwards around eight.

Dr Kurji: Nine probable and one confirmed.

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Hon Mr Clement: Nine. This is the state of it as of today. As a result of the one confirmed case, it is clear that in some manner the disease has jumped from just birds and mosquitoes as the originators, to human beings. I would like to say that unfortunately that was to be anticipated because of the expansion of the virus throughout North America. This has been how the disease has been tracked.

I am going to defer to a public health official in one second, but let me state that in this year's budget there is an additional $9-million allocation for the control and prevention of West Nile virus. We have been involved in larviciding programs; that is to say, finding likely places where mosquitoes breed and destroying those places before the larvae hatch. We have a standby arrangement with respect to pesticide which we have not used to date. I leave it to the public health officials to work with the provincial medical officer of health to make that determination. And of course there are education programs and publicity programs and what have you.

Let me state as a caveat—I stated this yesterday for the media—that if the definition of success as a Minister of Health is the eradication of mosquitoes in Ontario, I'm never going to meet that definition. We live in a province with lots of mosquitoes and that is not going to change. The fact of the matter is, we have a new disease, and although we had hoped that it would not make this kind of progress, it has. We're going to be learning as we go how to manage this disease.

Of course, we all hope that at some point there will be some form of eradication or vaccination or some other method of dealing with it once and for all. But in the meantime, we should take appropriate and common-sensical measures as a population that's used to trying to combat mosquitoes and as a population that really does not want to get bitten any more than we have to. With that, if I can leave this to my official here. You can identify yourself.

Dr Kurji: Dr Karim Kurji, public health branch. As the minister has correctly said, this is a relatively new disease in the western hemisphere. It started out in 1937 in the West Nile region of Uganda, where the first cases of West Nile virus originated. It wasn't until 1999 that the western hemisphere saw the introduction of the West Nile virus in New York City. We've now been amassing a fair amount of experience with the virus—

Interruption.

The Chair: I wonder if I could ask all people in this room to kindly turn off your cellphones and pagers. I will not have another interruption. Thank you.

Dr Kurji: We've been amassing a fair amount of experience with the virus recently. Our efforts basically have concentrated on the public education side. The essential thing here is to stop the mosquitoes from biting human beings, and hence much of the effort has concentrated on public education campaigns.

As you know, when the virus affects individuals, most of the individuals are asymptomatic. There's a very small proportion who really develop symptoms and most of those individuals develop symptoms like flu-like illness. They may get headaches, myalgia, fever and suchlike symptoms. A very small proportion, something like one in 150 of those, is going to develop a serious complication such as encephalitis. Encephalitis is really an inflammation of the brain, and hence one tends to get neurological side effects from that. These are the more critical instances.

What we really have to do is put the whole thing in perspective. We have, for example, injuries killing about 1,900 people in Ontario, tobacco killing about 12,000 people in Ontario. So far we've been fortunate in that nobody has died of this particular illness in Ontario, so from an epidemiological standpoint it certainly isn't a disease that warrants a lot of attention. However, it is a new disease, it is an exotic disease, and we're still learning about it.

The ministry has had an annual scientific meeting, which was organized in February this year, prior to the onset of the West Nile virus activity. We invited experts from the United States to elaborate on their particular larviciding programs and their particular programs with regard to the control of the mosquito populations. We have always insisted that any decisions that are made are science-based decisions, and hence all the medical officers of health were party to discussions with those experts.

Subsequent to that, the ministry has made available a number of protocols to the medical officers of health. We have been working very closely with the Ministry of Environment, and we have been providing materials to them. Essentially, what we have concentrated upon is a surveillance program. The initial surveillance was based on bird surveillance; bird surveillance because they tend to be indicators for when humans might get affected. Then we had to make sure that the mosquitoes were also infected in those particular localities, and so we have been putting into place a number of mechanisms for mosquito surveillance, including collaborating with Brock University and with our federal counterparts.

Following that, there's a mammal surveillance, which includes human surveillance. In a mammal surveillance there's a host surveillance where, should a host die of West Nile virus-type activity, initially the brains are tested for rabies—we know that seems to be more common—and then some testing is done for West Nile virus. Currently, there is some limitation to the testing, but at least that was in effect at the time this started out. Then of course there's the human surveillance with the surveillance of encephalitis cases. I would say that not a day passes when we are not in contact with the individual medical officers of health where there are probable cases, and we bring in to bear a number of experts from Health Canada, those who may have mosquito control expertise, to participate in the decision-making. The ultimate decision-making would be in the hands of the local medical officer of health, but this decision-making is done in consultation with adjoining medical officers of health as well as the public health branch and the various experts I have just mentioned.

So the efforts to date have concentrated on the public education message. If we were thinking at all in terms of going further than that, then I think, as the minister pointed out, funds have been made available to the local health units. This year in March $2.5 million was made available to the local health units for larviciding activities and on top of that the minister committed another $9 million in August of this year.

With respect to decision-making as to what one should do subsequently, the jury is still a little out there. There are a number of factors that one has to take into account: the numbers of cases; whether they are vulnerable populations, shall we say; the season; the weather patterns, because mosquitoes can be killed off naturally; the efficacy of the adulticiding, which would now be the area that one would really be looking at. One has to balance all this against the health and environmental effects of any of the methods that are used. The most common health effects would be asthma in the case of some of the

pesticides that would be used. In terms of environmental effects, there would be effects on bees, on other birds. So one has to, in an ideal world, consult with the local community and have a sense for whether the risks outweigh the benefits. So that is the general process that is used in this instance, and we try to look at the scientific experience of our colleagues to the south. This is an evolving area.

Mr Chudleigh: Thank you very much.

Hon Mr Clement: There will be an examination when this session is over. I hope you got all that down.

Interjections.

The Chair: I think there's still five minutes. Mr Miller.

Mr Norm Miller (Parry Sound-Muskoka): Mr Minister, the first question I'd like to ask has to do with CT scanners. First of all, I'd like to commend the ministry for the large increases in funding for hospitals across the province but also in my riding of Parry Sound-Muskoka. I was very pleased to see that earlier this year.

Certainly from the perspective of my riding, probably the most talked-about item is CT scanners in the health field. Currently there are no CT scanners within the riding of Parry Sound-Muskoka, although I believe that Parry Sound hospital has an approval to get a CT scanner and it will be happening when the new hospital is built, I believe in 2004.

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But the two other acute care hospitals, the South Muskoka Memorial Hospital and Algonquin Health Services in Huntsville, are keenly interested in acquiring CT scanners. I think the local health community, the physicians, are increasingly concerned about having CT scanners as basic diagnostic equipment. They also identify it as an issue in terms of retention of emergency room staff. And certainly I'm hearing from lots of people the desire to have CT scanners in the riding.

I guess my question has to do with the balanced budget requirement to be able to apply for a CT scanner. In the case of both Huntsville and Bracebridge the communities are willing to fund the capital costs of the CT scanners, but in both cases I think the hospitals do not currently have balanced budgets, so they don't get to first base in terms of an application for the CT scanners. Is that policy going to be reviewed, the balanced budget requirement for a hospital to be able to apply for a CT scanner?

Hon Mr Clement: Thank you for the question. Certainly we have dialogued with the various hospitals on a case-by-case basis and tried to understand the particular needs of the community. That's not only in Lake of the Woods; that's throughout the province. Some initial meetings did take place, as I understand it, earlier in the year. There were certain parts of the criteria met and other parts where further dialogue would be needed.

My understanding is that the two facilities in question, Huntsville District and South Muskoka Memorial, have been encouraged by the branch office to take another try at a submission that would be more of an integrated submission. The proposal is still a live proposal, as far as I'm concerned, and I would like to be working with the various hospitals in the Muskoka district to see if we can find a solution. Certainly I'm aware of the local public support.

The Chair: Two minutes, Mr Miller.

Mr Miller: Both hospitals are keen to have CT scanners themselves, in particular for medical purposes. They talked about treating strokes, in fact. When you treat a stroke you need a CT scanner to be able to identify what treatment to give, and it's quite time-sensitive. I think it's within the first half-hour of somebody arriving that you have to be able to establish what treatment to give.

Getting back to the balanced budget criterion, in the case of the South Muskoka Memorial Hospital, they currently had a review done that showed they're an efficient hospital. They also have a kind of special circumstance in that they built a new wing on the hospital last year. I don't think their operational funding was changed to reflect that new wing that was built on to the hospital. They've recently had an assessment done showing they're an efficient hospital. I guess that's why I'm asking what balanced budgets have to with that CT scanner application.

Hon Mr Clement: Yes, I'd be happy to—

The Chair: Minister, we've run out of time for this section, but hopefully that can be carried forward to your next round of discussion. Thank you, Mr Miller. We now go to the official opposition.

Mrs Pupatello: Minister, I'd like to continue the discussion we had earlier about the hyperbaric chamber affiliated with the Toronto General Hospital. You suggested earlier that if professional information was made available you would be taking that into consideration, potentially. I think your answer was somewhat more hopeful. The staff seemed to suggest that it was a decision that was made that it is going to be closed for 15 months. You suggested that if there was more information, it might be something you would consider.

Dr Brian Egler, who is the director of the Hamilton Health Sciences hyperbaric unit, is quoted directly as saying that Toronto's unit "cannot simply be shut down for such an extended period of time.... We are unlikely to be able to accommodate on any regular basis more elective cases than we are currently dealing with." CritiCall has also commented and suggested that they will have to redirect patients to Hamilton, Ottawa and even Buffalo, New York, as required.

In advancing that information, Minister, if there's a doctor involved with Hamilton, which is what you've suggested is going to be your fallback position from the closure of the Toronto General hyperbaric unit, that apparently is not going to be an option. On an emergency basis, which was brought up by your staff, CritiCall has already stated that they're going to have to be sending people to Buffalo, so that maybe a year from now we'll have to bring your OHIP department back and ask, "How much are you spending in out-of-country for this parti-

cular procedure versus the cost to have had it maintained at Toronto General all along?"

A letter served to you by the Canadian Council on Clinical Hyperbaric Oxygen Therapy and dated August 27 suggested to you that:

"A decision to close Toronto's only hospital-based MOH-mandated chamber ... for up to two years will put many lives at great risk and deaths may result unnecessarily.

"Absurdly, the closing is necessitated by a real estate agreement between the UHN and the MARS project (a medical and science research endeavour). That agreement stipulates that a roadway (which runs through the ... hyperbaric department) for demolition vehicles be available by" a particular date. Drawings apparently do show alternatives are available, as opposed to having the roadway run right through that chamber. If that in fact is the case, Minister, would you please tell the committee today that you might reconsider the decision and in fact step in and potentially halt the decision to close that hyperbaric chamber for 15 months?

Hon Mr Clement: I have some comments to make on this, but Allison Stuart wishes to comment. She's been the one most closely associated with the dialogue.

Ms Stuart: In terms of the agreement with Hamilton Health Sciences Centre, the Hamilton Health Sciences Centre has agreed to deal with the emergency hyperbaric cases that arise, and those are ones that are likely to happen because of something like getting the bends and so on if somebody has gone underwater. Those arrangements are in place. There are roughly 70 cases of that in a year. That accommodates not only Toronto, but people are flown into Toronto to UHN from across the province for this service. That piece of it, in terms of people being flown into Toronto, whether they fly into Toronto or fly into Hamilton is not considered to be critical in terms of getting this emergency treatment.

In terms of the other cases that may use the hyperbaric chamber, my understanding—and I'm by no means an expert in the area—from a clinical perspective is that the research is quite equivocal in terms of the benefits, and the accommodation of those patients who have been receiving hyperbaric treatment for non-emergency cases will be addressed on a case-by-case basis as to what would be helpful.

The issue around the redevelopment—the good news is that we're looking at UHN completing its process of redeveloping and becoming a premier hospital for not only the Toronto community but really beyond that, for Ontario and beyond that again. Part of that means that there is a lot of accommodation and moving around that has to occur. The issue around—

Mrs Pupatello: Can I get you to just expand on one item that you've said? Based on the information you've just given on how they can do without that unit for 15 months, why would you encourage them to reopen it in 15 months?

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Ms Stuart: There is no plan on the part of UHN to close the unit on a permanent basis. I know that's a concern by some people involved in the field around this, but we've been advised there isn't a plan to do that. There is the expectation that once the reconstruction has taken place and the hyperbaric chamber—which is not even being moved; they're getting a brand new hyperbaric chamber—is in place in around 15 months' time, they'll not only be able to accommodate the emergency cases that have been diverted to Hamilton but will also be able, on an as-needed basis, to accommodate those cases that are not emergency. I know that concern will probably stay with individuals who are interested in this area until there is the ribbon-cutting for the new hyperbaric centre.

Mrs Pupatello: Minister, I'd like to—

Hon Mr Clement: Are you moving on to another topic, or can I add something in this regard?

Mrs Pupatello: Yes.

Hon Mr Clement: Certainly there has been a barrage of commentary and letter-writing with respect to the future of this procedure and chamber. I want to assure you that we take every comment seriously and do try to follow up to make sure that—from our perspective, obviously health and safety are our number one consideration.

Mrs Pupatello: I need to give you some more information, Minister, regarding the Visudyne coverage. We spoke earlier, before the break, about the fact that the general public wasn't aware that it was only going to be covered for people once they had reached a level of blindness of 50%. I think this would be shocking to people, given the kind of degenerative disease it is. It's as if, if you were treating a cancer, you could only access the treatment once you're cancerous enough. That's just completely against everything the medical professionals would advise. The earlier you get to this kind of treatment the better, for these people. I can't imagine that you would approve of the medical community waiting till they reach 50% blindness before you would cover them with this drug.

Dr Patricia Harvey is an ophthalmologist and retina specialist with the eye institute at Toronto Western Hospital. She has just stated to us that there is no scientific evidence to support the notion that patients must have 50% vision loss before they can be administered Visudyne. She says it is absolutely ridiculous to think that they should have to wait. She says the sooner the treatment, the better; the greatest benefit is in the beginning, and this can reduce the severity by a lot. I would like to have your comments based on that professional advice by someone who works in the field and works with the drug.

Hon Mr Clement: I have not talked to her directly, so I would not want to comment on something until I have had that conversation.

Mrs Pupatello: I understand that she has tried to speak with you directly about this.

Hon Mr Clement: I'll certainly follow up with that, because I was not aware of that. From our perspective, in any drug review we are following clinical guidelines and safe practices. We would not do anything that was considered by clinicians to be unsafe. That's my understanding. Does anybody—

Ms Stuart: I'm going to start, and then I will turn it over to Dr McCutcheon.

The Chair: For Hansard, would you identify—

Hon Mr Clement: Allison Stuart, director of hospital programs.

Ms Stuart: In terms of the Visudyne, the clinical guidelines for use of Visudyne were established by clinicians, not by the ministry, and they are consistent with the direction that's been provided by the federal government in terms of approving the drug for specific usages. So it is approved for a specific use and then the guidelines are followed. In the treatment of individuals with this disease, the physician will complete a document that shows they have met the criteria and then the treatment can be started right at that time. Each—

Mrs McLeod: I don't want to interrupt, but we have some very specific questions. Rather than the things we know, we'd like to get some information tabled so we understand what we don't know. So if I may—

The Chair: Go ahead.

Mrs McLeod: I have the bulletin, and I'm confused by the bulletin. As I indicated earlier this morning when my colleague raised this issue, we'd appreciate having the medical advice that you've received tabled. I'd also appreciate having the federal criteria tabled, because I understand there is some question about whether or not all three of the criteria applied in Ontario are in fact federal requirements. My understanding is that although I think seven or eight other provinces fund Visudyne, Ontario is the only one that has said the loss of visual acuity has to be equal to or worse than 20-40—we're the only ones who have that in place—and that that particular criterion is not part of the federal guidelines. If I'm incorrect in that, I'd certainly appreciate knowing that. I'm not pretending that I can make clinical judgments about this, but I'm hearing a lot of confusion on the basis both of clinicians and of what we understand the federal guidelines to be about Ontario's decision.

Lastly, I am also confused about the fact that the second criterion indicates very clearly that treatment has to be commenced within 30 months after initial diagnosis. My mother had wet form macular degeneration, and I know it took some time for her vision loss to actually develop. So one of the questions I have is, where is the consistency between these two things? If the treatment has to be begun within 30 months to be effective, and that's a clinical judgment, and your vision hasn't deteriorated to the 20-40 level within that period of 30 months, now you're disqualified under Ontario's criteria.

So those are a whole set of questions. We didn't want to take the time today to go into the whole history. We've been fairly acquainted with that, but we need some very specific answers.

Hon Mr Clement: With the greatest of respect, Mrs McLeod, you pose a lot of questions, and it is unfair to those listening in or watching or reading the reports afterward to pose a lot of questions and not allow the ministry an opportunity to answer those questions.

Mrs McLeod: I appreciate that, Minister, but what I'm looking for are the specific answers and information.

The Chair: Minister, it's my job to see a fair balance there, and I'm happy to be appealed to in that regard. I think we did have some response from the ministry. There has been a specific request. Because this is the intervening party's time in each case, we let them have some latitude about whether a response is what they would like to hear or whether they'd like to move on to another question.

Hon Mr Clement: Well, I would like to state for the record, Chair, that I understand that ruling, but it is difficult for us to allay concerns when concerns are put on the table and we don't have a chance to answer the concerns. That's my only point.

The Chair: I will have regard for that.

Mrs McLeod: Mr Minister, simply to put on the record that I am not looking for verbal assurances; I'm looking for, in print, the criteria that are the guidelines that Ontario claims are federal guidelines guiding your decision, and I'm looking for, in print, the medical advice on which you founded your decision.

Hon Mr Clement: Well, Mrs McLeod, at no time have we had an opportunity to respond to that even verbally today. That's my point.

Mrs McLeod: I'm not looking for verbal responses. I had hoped you would table—

Hon Mr Clement: I would like the opportunity to at least provide a verbal response, because maybe members on this side want to hear the verbal response.

The Chair: Minister, when the members from that side have their time, they'll be able to provide you with that opportunity. Now we'll turn to an answer to the question posed by Mrs McLeod. Sir, could you please introduce yourself again.

Dr McCutcheon: Dr McCutcheon, assistant deputy minister, health services.

Just to make a comment on the guidelines, the guidelines were established using the best advice available from the ophthalmologists that were consulted in the process. What we are committed to do is, over time, to continuously review guidelines in light of new evidence that comes forward. Ontario prides itself in terms of the way it develops its guidelines, not only for its drugs but also for other procedures etc, that they use the best available advice and evidence. If the evidence changes and the guidelines need to be adjusted, certainly there is the flexibility to deal with that. But the initiation of the program was based upon guidelines that were provided by ophthalmologists who are retinal specialists, and that's the procedure that we followed.

The Chair: Mrs McLeod?

Mrs Pupatello: Yes, you go ahead.

Mrs McLeod: There are so many areas, between the three of us.

The Chair: You have approximately six minutes, I believe.

Mrs McLeod: On this particular issue, I'll wait for the actual information on those two areas to be tabled.

I do want to ask about mental health, which we didn't have an opportunity to raise this morning. I'll again be very specific and refer to estimates documents.

In June, Minister, you would have received communication from the Canadian Mental Health Association, Ontario division, and the Ontario Federation of Community Mental Health and Addiction Programs, together representing 236 community-based mental health and addiction services, who are extremely concerned about the fact that they have not had increases in their base operating budgets for some 10 years, which appears to be a fairly consistent reality for most community health services, as I'm beginning to understand it.

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My concern is that, although they expressed the need to you prior to the budget, their needs were not reflected in the budget. I've looked for some response to the community mental health needs in the estimates, and I see that there is an increase of some $1.36 million, which, if my calculations are correct, is about 0.3%. It certainly is not the even minimal 2% increase that community mental health was asking for.

I was also alarmed to see that, in an area in which we know there are tremendous unmet needs, you underspent by $12 million in your actual figures from your estimated expenditures for last year. Again, I find an underexpenditure in community health services absolutely inexplicable and unacceptable.

Minister, my question is, where's the funding for community mental health?

Hon Mr Clement: Certainly, Mrs McLeod, we have had a commitment to appropriate funding in this area and to the appropriate innovation in this area to have a true system of community mental health available to the population. We have been in a state of waiting with great anticipation as the mental health implementation task forces complete their review and complete the writing and delivering to us of their findings, a process which has just reached another stage as they deliver their findings to us.

My commitment to this community has been when we have a way to proceed with true community mental health innovation and reform, which we are getting through our mental health implementation task forces, that of course funding and the resources necessary to set on that path will be of great importance to us, as to them. That's the plan.

Mrs McLeod: I appreciate it, Minister, and I've been waiting—as you have, apparently—for the implementation team reports to come in. There is not a chance, not a single, solitary chance, that those implementation teams will recommend less community mental health service than is currently provided.

Hon Mr Clement: Right. But we have to know how to spend it.

Mrs McLeod: I'm sorry, but I don't accept as an explanation for there being no funding for community mental health, in this year's budget or estimates, the fact that you're waiting for the implementation teams' reports. If you're serious about delivering mental health services in the community, why would you not at least provide a 2% increase to the community agencies currently meeting those needs in the communities, which have not had an increase in their base budgets for 10 years?

Hon Mr Clement: Mrs McLeod, I think it's important to know that the money we spend on behalf of the people of Ontario is spent wisely and is spent effectively and is spent on the priorities of the sector. That is precisely what the mental health implementation task force reports are all about: a plan of action, a road map that we can take for true community mental health to be successful and efficacious. That will be the way we can ensure that the money is spent in a way that'll help people and help them help themselves. I think that's an answer that I hope we all aspire to as public servants.

Mrs McLeod: You're not helping the people in community mental health agencies very much, Minister. But can I ask you just finally, when are you going to not only expect to receive but to release the community mental health implementation reports? They're well overdue now.

Hon Mr Clement: We've just started receiving them. It's a very complex and important exercise. We are in the midst of analyzing their findings as the reports come in.

The Chair: Ms McLeod, Minister, thank you. We now turn to the third party.

Ms Martel: If I just might follow up on that line of questioning, Minister, my understanding is that the deadline for the receipt of the reports has been extended to December. Is that correct?

Hon Mr Clement: At this point I'd like to introduce Gail Ure, the executive director for the health care programs division. She can give you an update.

Ms Ure: Gail Ure, executive director, health care programs. Initially we talked with the mental health implementation task forces, and interim reports, in many cases, were required. We have received either an interim or a final report from the majority of the task forces. In some cases it was final, because in some cases the task forces, such as in your area, were started many months ago. In other areas it has been taking longer. In the northwest, for example, in Mrs McLeod's area, we have the final report with the exception of costing for that area. So it depended when the particular task force was developed and what the magnitude of their work was. In some cases, such as Toronto-Peel, it involves a large number of agencies, a large jurisdiction and a very complicated set of programs. They're doing the consultation on that as we speak.

Ms Martel: I saw their document; it's quite large. It's going to take a while to get the final document in. So my

question is, have you given some deadlines to when the last report is in? As I hear you speak, it sounds like you're saying funding announcements are going to be based on all of the reports being in. So when will that occur?

Ms Ure: The final report from the provincial task force, the overriding group, is December. Their last meeting will be in December. Prior to that, we're working with those agencies, those task forces, that have not submitted a plan to ensure that they both do adequate consultation but also get the plan to us. For example, in many of the reports we've got interim reports such that we can make estimations in terms of what the minister was saying in terms of some of the requirements.

Ms Martel: Here's my concern. It's not a question; I guess it's a concern that I pass on. I think you will be seeing quite a varied degree of how to move forward, depending on where you live in this part of the province, with some of the task forces coming forward with a recommendation for quite a significant and complete overhaul of the system and others wanting more money at the community level. I think you're going to have great difficulty in finding some mid-ground here.

So I make this suggestion based on what Mrs McLeod has said. I don't think anyone will come forward and say, "We don't support local, community-based agencies like CMHC trying to provide front-line service." Because I don't think any one task force will come forward and say that, I would encourage you, in the meeting you're going to have with them, I understand, Minister, in October, to give them some indication that in fact for those community-based agencies you're going to increase some funding soon. They are having great difficulty retaining and recruiting people to work in their community-based agencies. It is unlikely they are going to be wiped out in any of the reports. I suspect most reports will come forward and say, "Strengthen the community-based sector." Knowing that is probably the case, I would really encourage you to find some money, as you yourself promised, Minister, at one of the conferences you were at, above the 2%, to do something in this sector before they lose even more staff who deal with a very vulnerable population.

Hon Mr Clement: Yes, I take your point. I have a couple of things to say. First of all, we were able, at least on the addiction services side, to annualize the 2% through what I thought was a very creative approach by this government in order to do so and using some of the gambling revenues from our wonderful casinos to that effect. The only other point I would make, aside from taking your point, is that this is not going to be a cookie-cutter approach, where what works in one community is necessarily what will work in another. That's why we're taking the reports very seriously. We see them as individual roadmaps. Some aspect of mental health will be integrated, but other aspects will be very particular to the local circumstances and challenges that individuals face.

Ms Martel: I would like to make a couple of requests for information, if I might, and then move on to a different topic. With respect to the 20,000 new long-term-care beds, Minister, you indicated about 6,600 had been built and another 13,400 are currently under development. I wonder if your staff could give me a breakdown of the beds in the for-profit sector and then in the charitable sector and then those that are municipally owned.

Hon Mr Clement: Sure, I think I can give you off the top of my head the general numbers for all 20,000, which I understand at one point anyway were 53% in the commercial sector and 47% in the non-profit or municipal sector. That final number might have changed, but that's what it was. Maybe I'll defer to Gail Paech, the assistant deputy minister in charge of this program, to give us the most recent tallies.

Ms Gail Paech: Thank you very much, Mr Minister. I'm Gail Paech, assistant deputy minister, long-term-care redevelopment. As you know, with the government's initiative of the 20,000 it was an open, competitive process for organizations to seek an allocation. In the allocation of the 20 beds, as the minister has indicated, the total number of beds for the not-for-profit sector is around 48%, and for the for-profit sector it is at 52%. When we looked at the analysis in terms of those types of organizations that made application to be considered for the allocation of the 20,000 beds, we had approximately 12,000 applications made by the for-profit sector and approximately 9,000 applications made by the not-for-profit and charitable sectors.

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When you look, though, at the number of beds that were given in terms of the number of requests that were made by each of the various sectors, there was a higher proportion of allocations made to the not-for-profit and charitable sectors in terms of the applications made than for the for-profit sector.

Ms Martel: You might have the answer for this as well, then. I'm going to page 16 of your remarks, Minister. You talked about the commitment that was made in 1998 to add $1.2 billion to the long-term-care sector, which I thought was over eight years, although this document says six. But that's fine.

Hon Mr Clement: We accelerated it at one point during our mandate.

Ms Martel: Would you be so kind as to provide to the committee, especially on the CCAC, community-based long-term-care side, the allocations that have been made, beginning in 1998 when that particular money started to flow? I'd be interested in knowing how much of that $1.2 billion, about $555 million I guess, targeted for the community-based sector has actually been delivered.

Hon Mr Clement: Actually been delivered?

Ms Martel: Flowed, allocated.

Hon Mr Clement: All right. I don't have that number. We might have to take that one under advisement to give you a complete flow on that.

Ms Martel: Did you do a double allocation, then, in one year? Because you said it's been shortened to six. So is that my assumption?

Hon Mr Clement: This was before my time but I recall, just by being around here too much, that we did accelerate it at one point. Did we not?

Ms Paech: My understanding of your question is, if it's in terms of the acceleration of the long-term-care redevelopment in terms of the 20,000 beds, that was the acceleration.

Ms Martel: No, I'm speaking specifically of the CCAC, community-based long-term care.

Hon Mr Clement: The community care portion.

Ms Martel: Yes. So I'd just like to know, is it still $555 million essentially? I assume there was an almost equal split between the two sectors—the long-term-care facility sector—

Hon Mr Clement: And the community, yes.

Ms Martel: —and then if that's still rolling out over an eight-year period, where we are. If you can start from 1998, if that was indeed the first year of the allocation, how much has been allocated in each of the years to date?

Hon Mr Clement: OK, I'm sure we can get you that information.

Ms Martel: OK, that's great.

Then I'd like to ask you some questions about MRIs and CAT scans. The budget document talked about $28.3 million being allocated to increase the hours of operations for hospital MRIs by 90%.

Hon Mr Clement: Correct.

Ms Martel: I'm curious when you expect that to be achieved and how much of the waiting list would then be dealt with by having that change in operation to a 90% level. I don't know what your base is—if you're starting at 60%, 70%. So I'd like to know what the base was as well.

Hon Mr Clement: Increasing the number of hours is the short answer, but I'm sure someone can give you a much more detailed answer that that. Allison Stuart can.

Ms Stuart: Thank you very much. Allison Stuart, hospitals branch. In terms of the increase of the funding, we knew that the hospitals that were operating their MRIs—although we were funding them as if they were operating them 40 hours a week, we knew that they were operating them longer than that and they were having to absorb some of those costs in their overall budget. So we did increase the funding that we made available. The question of how much of that is going to translate into new procedures is really hard to answer, and I'll explain why. It's hard to answer because we know they're already providing those services, so that if they were, for example, running their MRI at 50 hours a week, then our funding would mean that they would say, "Oh good, we don't have to take money out of obstetrics so as to be able to fund those extra 10 hours." So it's not a direct translation into new services.

Ms Martel: How do you arrive at a figure that says that $28.3 million is going to allow us to increase operation to 90%? My question is, 90% of what? Are you asking people to work 50 hours a week, 40 hours a week? Where were you starting from, and how do you get to a total of $28 million to buy you something?

Hon Mr Clement: An increase of 90% on the current funding would increase the number of procedures available, some of which were covered by hospital budgets but some of which were not, because hospitals either shut down machines or used them for other purposes—WSIB, for instance, and that kind of thing.

Ms Martel: Do you have some kind of standard across the hospitals which have MRIs that says how many hours per week you're expecting them to operate? Is there a standard, and are you paying to that standard?

Ms Stuart: Hospitals were all at 40 hours per week and a total of 2,080 hours per year. What has happened now is we'll have three groups of hospitals: hospitals that stay at the 40 hours a week; hospitals that will increase and be functioning at, instead of eight hours a day, 12 hours a day—and I apologize for changing language right then, but right now I can't do my math on the run—and then other hospitals that will be running their MRIs basically at 16 hours a day.

So it really depended on the kind of hospital and the kind of volumes they were experiencing—the level of funding they received and then the number of procedures we attached to that level of funding. If they're getting the basic amount for eight hours a day, then they're being expected to provide around 3,400 scans a year. If it's 12 hours a day, then it's around 4,900 scans a year. If it's the full 16 hours a day, it's 6,500.

What we will do is track that. They report to us on how much they actually do.

Ms Martel: In looking at this, can you give me a close estimation of the number of new scans that will now be done with that $28.3 million?

Ms Stuart: We have not done that because, as I was trying to explain before, and I'm not sure that I did a very good job of it, they were already functioning. Our funding was in response to the level of service that these hospitals were currently providing. So there will be some new service, but we don't know how much of that will be new service and how much of it will be allowing the hospitals to focus their funding—

Ms Martel: Redirecting their funding back, or to where it was before.

Ms Stuart: Right.

Ms Martel: I find that a bit problematic because I would have hoped part of the point of the exercise was also to increase the number of scans.

This leads to my next question, which is, how much work was done with any of these hospitals that are not operating at 16 hours right now to see what their capacity is to actually increase their volume so that you don't have to look at establishing new for-profit MRI clinics? What was the level of discussion and what analysis was done to see how much you could increase capacity over what it currently is in the public hospital system to reduce waiting lists for these diagnostic services?

Hon Mr Clement: Certainly, we have a very detailed discussion with hospitals every year to consider their

operating plans and their business plans. So that's a very detailed circumstance.

If I can maybe take a run at this: in accordance with what Allison was saying, the thing was that there are some hospitals that have, let's say for the sake of argument, an eight-hour shift, others that have a 16-hour shift, others that have an eight-hour shift for publicly funded, medically necessary services, and then have a shift for other types of services such as WSIB claims or third-party payer claims. So their hours of operation are already beyond what we pay for because they, as much as anyone else, don't like to see the lights shut down and the doors closed if there is a way to utilize the procedures.

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I have been informed, by those who help operate the hospitals and those in our ministry who oversee that, that there is potential for increasing the number of scans that are part of the publicly funded, universally accessible, medically necessary part of it, which would edge out some of this other activity that was using up the time.

Ms Martel: Minister, you're going to pay for scans in what I would describe as for-profit MRI clinics, and my question is: before you went down that road, what work was done to deal with public hospitals who already—

Hon Mr Clement: A lot of work.

Ms Martel: OK. What was the result of that? Was there no way to increase the number of scans in some of the hospitals only working eight hours?

Hon Mr Clement: Yes. The answer is yes. Of course we're increasing the scans.

Ms Martel: Yes, but I just had one of your staff tell me she couldn't give me that number. That's why I was trying to get up to that number in the first place.

Hon Mr Clement: She can't give you an exact number, but I can assure you there will be an increase in the number of scans. They're part of the medically necessary, universally accessible service.

Ms Martel: OK, but wait a minute. Let me back up. You're giving them $28.3 million. My specific question was, how many more new procedures is that going to provide to reduce waiting lists? I think I heard your staff say pretty clearly, "We can't tell you that because some portion of that money went to pay hospitals because they were diverting their money to continue to run. We don't know what the new procedures are going to be." So I'm having difficulty determining how much work went on to clearly show that you needed to move into the for-profit sector if you can't even answer that simple question about how much $28.3 million is now going to buy you in terms of new procedures.

Hon Mr Clement: Let me say again, every year there is a great deal of work that is done in consultation with the hospital sector on their needs and expectations for their budgetary planning purposes. This is a sector where there is currently in Ontario a mix of the utilization of the procedure for universally accessible, publicly funded, medically necessary services and for other purposes as well, including WSIB claims and third-party payer claims. That happens now. That occurs right now in the hospital setting, because that is the only place where we have MRIs and CTs presently.

The answer to your question is, right now there's a mix. Right now, some hospitals eat the added usage of the MRI/CTs for medically necessary services as part of the budget; others don't. But as a result of the dialogue with hospitals and with a review of their operational plans for the year, there is a conclusion that was reached by the government that increasing the direct payment and the specified payment for medically necessary scans would in fact give us the results that we expected.

Ms Martel: Can I ask—

The Acting Chair (Mr John Gerretsen): We'll have to leave it at that. The 20 minutes are up. It's now the government side.

Mr O'Toole: I'm going to continue on the same theme if perhaps Allison would like to stay there, because I'm going to be asking. I think they've established a great deal of interest in your commitment to add additional dollars to the diagnostic equipment: CT and MRI. I think Mr Miller raised the question as well. I want to drive down to a little more specifically—I understand the current RFP for the process to go through is to be issued—I'm not sure if it has been issued—

Hon Mr Clement: No.

Mr O'Toole: —to allow not just the private operators; existing hospitals could bid as well, it's my understanding, in a hospital facility. This is really my question. I know my local Lakeridge Health Bowmanville site had worked for almost a year to develop and operate within their own existing budget the CAT scan, and they were close to being licensed, similar to Mr Miller—there were criteria that were developed. I had met with the Lakeridge Health Bowmanville physicians' group and Dr Tony Stone and a very progressive group of doctors and other medical staff. They were saying to me that this would help in the recruitment of new doctors; this would help cost avoidance in the case of their site. There's a lot of cost implied because of diagnostics not being on-site. They get transferred to Oshawa, and Oshawa is closed many times because of inadequate equipment, I guess. Other than that, it goes to Lindsay or Toronto. So you've got ambulance attendants and other costs that could be avoided if there was an on-site diagnostic tool such as a CT scan.

I'm just wondering: in the current climate, is introducing a set of new rules going to in any way jeopardize the lot of work that's been done over the past year with the Lakeridge Health Bowmanville site—being that close and now we've got a new process for them being available? It's a similar question to Mr Miller's question earlier.

Hon Mr Clement: I think that's a fair question and I can certainly indicate to you that we are continuing in dialogue on a lot of these issues. Sometimes it's a case-by-case resolution of these things, where we look at the individual circumstances and conditions in the community. I think what you're getting at is that there is certainly an argument to be made that circumstances

have changed somewhat in terms of the original criteria. I think that's what Mrs Pupatello was getting at as well. I'm certainly prepared to review that and see whether the original criteria are still applicable and still relevant and still helpful in meeting the needs of the community in this area.

Mr Chudleigh: The Ontario Family Health Network had its roots, its first clinic, in Oakville in the riding of Halton. I liked the concept when it started. It obviously gives patients 24-hour access seven days a week to get treatment, to get help when they need it. It avoids the expense of going to emergency rooms in hospitals. I understand that it has been expanded and, from the look of the budget, it's going to be expanded again. Could you tell me how this is working out and how successfully this has turned out in other parts of Ontario, as well as in Oakville?

Hon Mr Clement: I think we are gaining considerable momentum. Yesterday I was able to announce the establishment of four new networks in four different communities, including rural communities. The information I've received from the family health network agency is that the type of consultation they are having with individual family doctors is getting right into the nuts and bolts now, where they're doing cost-benefit analyses in terms of how they operate their practice under the old fee-for-service system versus how they'd operate their practice under the family health network, which is a different type of remuneration; considerably different.

As the doctors who were part of the media conference yesterday indicated, these things take a little bit of time. He used the example of the news media, so I'll use the same example: if someone asked the news media in the room to completely change the way they were remunerated, I'm sure that the news media, just like anybody in our society, would want to take some time to review what the impact on the bottom line was going to be for them and their families. That's a perfectly legitimate exercise to take place.

There is some hanging back by some family physicians who are waiting for the first wave of these networks to be established and then they're going to take a look to see how their colleagues are doing in that first wave. One of the doctors on hand indicated that his profession is somewhat conservative when it comes to these kinds of issues, but when you're dealing with monetary remuneration and how their practice is structured—those are pretty elemental issues.

All of which is a long way of saying we're making progress and we are signing more physicians to family health networks. Incidentally, they are showing a willingness to expand into a multi-disciplinary framework, either with nurses or pharmacists or dietitians. This is the next phase of their consideration once they get their practice set up under the new arrangements. You're right to characterize it as a 24-by-7 approach, where the office hours are expanded and, to the extent that the office is closed for some reason or other, there's an automatic nurse advice line that kicks in so that when anybody phones that number they're not left with just a voice mail recording. I think that's very important as well, for patients to have that kind of access.

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The doctors yesterday who were part of the announcement of the new networks were ecstatic about how this is going to benefit their type of practice and encourage them to engage in preventive medicine, encourage them to develop wellness strategies, encourage them to incorporate such things as special services for the seniors population in their practice. So I come out of it optimistic. I am impatient, as the rest of us are, to see more of these services being put in place, but I have no hesitation when I say it will occur.

Mr Mazzilli: Minister, certainly last year and the year before I sounded like an opposition member when it came to ambulance funding—

Mrs Pupatello: Not quite; not even close.

Mr Mazzilli: I would think so. Minister, I'm certainly happy that you listened. Can you give us some sort of a breakdown of how you expect to allocate the $32 million you recently announced?

Hon Mr Clement: I can give you some detail in terms of the breakdown: $3.3 million of that will be going to dispatch services. That will create 66 new full-time equivalent positions in the ambulance dispatch centres, which will improve the functioning of those centres. There is of course the $29.2 million that is directly related to ambulance response times. That means over 500 more paramedics will be part of the system.

Mr Mazzilli: Can I stop you there for a bit, Minister?

Hon Mr Clement: Yes.

Mr Mazzilli: The $29 million is on a 50-50 funding split, so would that be leveraged to almost $58 million? Is that how I can read that?

Hon Mr Clement: That's right. We are in detailed conversations with municipalities on those aspects of it. I don't have it all tied up in a neat bow yet, but with the funding we announced in the middle of August, the municipalities have taken that very seriously and want to have a dialogue with us. Can I defer to Gail Ure just on the status of where we are on that?

Mr Mazzilli: Absolutely.

Ms Ure: It's Gail Ure, executive director, health care programs.

The announcement, as you know, was only made a week and a half ago. It was made at AMO. We talked about the issues for ambulances and municipalities. What we need to do now and what we're doing now is developing an implementation plan. I will be going out and talking with each of the municipalities with regard to what their needs are, what they've put in initially as their needs and what the requirements are to deliver, because we're expecting the 50% funding on those issues. That amount of money adds up to $27.95 million.

In addition, there is $1.25 million for recapitalization for ambulances. The reason for that is that in March of last year we provided $10 million for new ambulance vehicles. Now, why would we do that ahead of time?

Well, ambulances take a while to order because they have to be special purpose, and the recapitalization money, the $1.25 million, is to ensure that they have the recapitalization for those new vehicles. That was also on top of the $5 million that was allocated in September for equipment and ambulances, and $5 million the previous year. So we've got the vehicles, we're working on getting the resources in terms of paramedics as part of the $27.95 million, and as the minister said, we're also working on the dispatch system.

Mr Mazzilli: If I can just stop you there for a second, one of the complaints that I heard before was not the 50-50 funding formula; it was being approved for new ones that was the problem. Is there going to be some kind of formula, either by human resource hours or by population, one per 1,000, that's going to put some equity across certainly the urban centres?

Ms Ure: At this point there is not an equity model as such that we've talked about.

Mr Mazzilli: The complaint I have heard in the past, obviously, was that the ones that were run by the Ministry of Health had a different capacity level.

Ms Ure: The dispatch centres?

Mr Mazzilli: No, the ambulance service. When it went to a 50-50 funding formula, the ones that had 70 got to keep 70 and the ones that had 35 were only approved for 35. So I'm hoping that with this new funding, there can be some equity spread out across the province.

Ms Ure: There are two parts to the funding for land ambulance. One is the land ambulance template where people were funded according to what they had previously, just in the conversion to municipalities. The second part is the response time. Municipalities put in what they thought they needed to give them the best response time within their jurisdiction. There's variability between urban and rural, but they put in what they thought, based on their analysis of best practices and their comparison with other municipalities. That's what we looked at and that's what the framework was designed to do.

Mr Mazzilli: When do we expect to have the fine details worked out in order to be announced in our communities?

Ms Ure: It will be over the next month that we'll be meeting with the individual municipalities and talking with them about the expectations for the money, as well as their plans that they originally submitted.

Mr Mazzilli: Thank you.

The Acting Chair: Mr Miller?

Mr Miller: How much time do I have?

The Acting Chair: You have exactly eight minutes.

Mr Miller: Oh, my goodness.

The Acting Chair: We can make it seven.

Mr Miller: The nurse practitioners: I was very pleased to hear that in the budget the funding for nurse practitioners has been doubled. In my riding of Parry Sound-Muskoka, a couple of applications for nursing stations, one in Rosseau and one in Whitestone, were turned down earlier this year due to the criteria. I think it's the 80-kilometre rule, that they're within 80 kilometres of the Parry Sound hospital. Those are projects where there is a lot of community fundraising going on for the capital portion of the nursing stations and there is a lot of community support. Certainly the communities are committed to the projects and they have the support of the district health council as well as the Parry Sound health centre. My question is, are these applications eligible for nurse practitioner funding under the recently announced nurse practitioner strategy and the doubling of funding that's happening?

Hon Mr Clement: My understanding is that we are in discussions to that effect, and certainly it is within the realm of possibility. Maybe I can defer to and introduce Mary Beth Valentine, our provincial chief nursing officer, who might also have a perspective that would be helpful to the committee.

Ms Mary Beth Valentine: I could perhaps elaborate a little bit. The $3 million that was announced for 12 communities earlier this year was to place 20 or more nurse practitioners in communities either without physicians or where they are severely underserviced for an extended period of time. We have had 11 of the 12 community meetings to date. In the Parry Sound area, there were a number of people from both east and west Parry Sound there. Communities identified areas that they felt were of particular concern, and the two communities that you have named were certainly identified as primary targets, more or less, for nurse practitioners.

The 80-kilometre requirement related to nursing stations is not a requirement in the nurse practitioner demonstration project. The nurse practitioner demonstration project is primarily geared to improve access in communities without physicians, and from that standpoint, as the starting criteria, the two communities you've identified are key for consideration.

At this point, the community is doing some follow-up for some further discussion themselves around other issues and concerns. There were also some other communities identified. So the community, under the leadership of the district health council in that area, is carrying on with some further discussion, and the ministry is prepared to be meeting with them as soon as the community is ready—I would imagine within the next two or three weeks—to engage in further discussion and look at how we can move forward.

I would just like to add that the reception in the communities we've been to has been tremendous. The communities have all had health care providers, and in some cases physicians were able to attend because they were evening meetings or they made an effort to get there.

Sponsoring agencies, groups such as the VON, CHCs, potential sponsoring agencies and municipalities, have been extremely supportive. So we've really seen tremendous response with communities very anxious to be able to proceed. We've also received a number of indications of interest from communities as nurse practitioners roll out with potential new announcements over the future.

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Mr Miller: Thank you. That's certainly in the area of Whitestone and Rosseau. They are an underserviced area and they aren't able to get doctors, even though I know they're designated as qualifying to have a number of doctors. But they currently have not been successful in getting doctors. There's a lot of support for nurse practitioners as being a way to bring health care to those—

Hon Mr Clement: I couldn't agree with you more. From our perspective, the debate is really over. These are underserviced areas or no-service areas of our province, and we have ample evidence that nurse practitioners, working in conjunction sometimes with remote telemedicine or other services, are perfectly capable of alleviating some of those concerns and providing the health care. So we are moving down that road, and we'll be seeing more of this.

The Acting Chair (Mrs Sandra Pupatello): You have two minutes.

Mr O'Toole: Also, you mentioned innovation in your envisioning statement for the ministry, and all of this is part of the family health network. But I just wanted to make some comments. I was very privileged to visit a demonstration at I believe it was Sunnybrook to watch the distance medicine. It's envisioned and certainly well embraced. They were actually doing a demonstration, a live, real demonstration from Sunnybrook to other remote parts of Ontario. I was quite impressed not just with the technology and the hardware but with the physician and indeed patient comfort with that whole new approach, the innovative approach that you've mentioned.

Maybe just in the remaining time—I know as part of the Ontario Family Health Network I've had the privilege of working with Ruth Wilson on a couple of visits and was quite impressed. There is, as you said, the e-physician project that I visited, where the physicians are gaining comfort with the new technology but they're also impressed—even they were commenting in the visits I had about how the drugs are checked with the little tablet they're using. I should ask you to spend some time on the commitment under the umbrella of the family health network to technology and to the broader goal of smart systems for health or some of the innovative issues that are out there that perhaps to the public aren't as understood or embraced because of a lot of demonstration stuff going on at the moment.

The Acting Chair: A few more seconds, John.

Hon Mr Clement: I'm very excited about it, actually. There's a lot going on in the IT field in health. From my perspective, it not only helps deliver better clinical care and outcomes but it also helps retain and recruit physicians who may be in remote or rural areas, who may have felt cut off from their profession. This is the same in the nursing profession as well, both professions. Now they have a direct real-time link. They feel part of a broader profession. So it's definitely part of our strategy to expand that.

Mr O'Toole: How do we stack up against other provinces?

The Acting Chair: Thank you, Minister. Your time is up. Over to the Liberals.

Mr Gerretsen: I'd just like to follow up on the nurse practitioner situation. How many registered nurse practitioners do we have in the province, Minister?

Hon Mr Clement: When you say "registered," do you mean—

Mr Gerretsen: Qualified.

Hon Mr Clement: Mary Beth Valentine, nursing secretariat.

Ms Valentine: I believe it's 469 who were regulated with the college of nurses. That's a bit off the top of my head.

Mr Gerretsen: How many are employed currently as nurse practitioners?

Ms Valentine: Some 289 are being funded by the Ministry of Health at this particular point. There are others who are employed in other types of situations.

Mr Gerretsen: So 289 on a full-time basis?

Ms Valentine: Full- and part-time. We have the number as they fill their college regulatory requirements. That's where the statistics come from. So I don't have a specific breakdown, but the vast majority of those are full-time positions.

Mr Gerretsen: Let me ask you this, Minister. That means there are about 180 or so qualified people who are not employed as nurse practitioners. Why? Why aren't you doing more to see that these people get particularly into underserviced areas?

Hon Mr Clement: I think I just spent the last 10 minutes telling you we are doing more.

Mr Gerretsen: What was the number you gave us earlier as to how many exactly are involved in these pilot projects you're talking about?

Hon Mr Clement: These aren't pilot projects, first of all. This is an expansion of funding. What are the numbers again?

Mr Gerretsen: Just give me the numbers.

Ms Valentine: Some 20 to 22 have been announced, but the commitment that was in the budget was to double the number of nurse practitioners who are employed. So that is a doubling of the 289, as I understand it.

Mr Gerretsen: So it's your plan, then, to have all of these people employed, let's say, within the next year. Is that what you're saying?

Hon Mr Clement: Yes. We'll have the funding in place for that.

Mr Gerretsen: You'll have the funding in place to basically fund all of the nurse practitioners who are qualified to practise their trade in Ontario?

Hon Mr Clement: We have the funding in place, that's correct.

Mr Gerretsen: My next question is on long-term care. I want to make this as simple as possible.

Hon Mr Clement: Thank you, for my benefit. I appreciate it.

Mr Gerretsen: I understand that under the current system the operators are collecting $3.02 more per

resident than was the case prior to August 1. Out of that, 87 cents goes to the operator as, I take it, additional accommodation costs. Am I correct in that?

Hon Mr Clement: That's my understanding. Yes, that is correct.

Mr Gerretsen: So the difference, then, which would be $2.15, is being collected by the operator, correct? The operator collects the entire sum of money. So he, she or it collects the $2.15, which basically has given you more room, because you're no longer paying that toward the accommodation of a particular facility, in order to pay more for the personal care and nursing services. Would you agree with that?

Hon Mr Clement: That is correct. That is a partial explanation of the increased funding for nursing and personal care. But, again, I wouldn't want to leave the impression that is the only way we are funding increases in nursing and personal care.

Mr Gerretsen: No, I realize you're topping that money up. But in effect, indirectly, the residents who are going to be paying the increase are paying $2.15 per day of that additional nursing care cost indirectly. They're giving it to the operator, and you're taking that money away from the operator.

Hon Mr Clement: I guess we're into differing versions of characterization, Mr Gerretsen. I would say that we believe our commitment as a government should be toward nursing and personal care. We believe those who can afford to pay a greater percentage of their accommodation in a phased-in way—that will be their requirement to do so. I think that's the way I would characterize it.

Mr Gerretsen: How many of the 61,000 individuals who are currently resident in our long-term-care facilities are completely subsidized?

Ms Kardos Burton: I think we had agreed earlier that we would get you the number.

Mr Gerretsen: You don't have that number?

Hon Mr Clement: We don't have an exact number.

Ms Kardos Burton: I don't have it right in front of me.

Mr Gerretsen: But would it be around 10,000?

Hon Mr Clement: John, in all respect, this is a committee of the Legislature. You deserve exact numbers, and we have undertaken to give you an exact number. So if you want us to do it off the tops of our heads, we're not going to do that. That would not be polite.

Mr Gerretsen: Let's assume that it's 10,000 for the moment. If you take the $2.15 times 365 days, and this is over a full fiscal year—I'm not talking about the current fiscal year; we're only talking about another five or six months—in effect you would be looking at close to—$2.15 times 365 times 50,000—probably something in the neighbourhood of $35 million. Would you agree that that's the number if there were 10,000 people fully subsidized? The rest of the people would come up with $35 million over a full fiscal year. We have no mathematicians in this huge department, where we've got 48 people representing here today?

Hon Mr Clement: I think they're being cautious, John, because this is serious stuff here.

Mr Gerretsen: You're darn right, Minister. It's very serious stuff, particularly to the people who were hard-hit in June and July this year, who all of a sudden have to come with an extra 230 bucks.

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Hon Mr Clement: I'm glad you agree with that. Rampant speculation is not particularly helpful, so we would like to give exact answers.

Mr Gerretsen: Well, Minister, let's deal with another aspect of that, and that's the whole question of accountability. You mentioned this morning that a regulation was changed whereby at one time, I take it, there was a firm regulation that each resident would be given a minimum of one bath per week. Now in a more loosely defined way it's left up to—there was some discussion as to whether it's the registered nurse or whether ultimately it's the owner or the operator of the facility or what have you. Would you not agree that there may be some concern among some people—some caregivers, perhaps, or some residents—that if you don't put a minimum finite number in the regulation, it may very well turn out that some of these people may not get a bath for a couple of weeks or 10 days or whatever?

Hon Mr Clement: The short answer is no. Again, I disagree with your characterization of this as somehow, in your words, "loosening" the regulations. This, in our view, makes it clear that there is a daily standard of care which is expected by this government to be adhered to daily. In our view, that is a strengthening of the standard of care, not a loosening of the standard of care, as you characterized it.

Mr Gerretsen: Are you suggesting that these people are going to get daily baths?

Hon Mr Clement: I'm suggesting that in certain circumstances where the standard of care requires it, that is exactly what they will get.

Mr Gerretsen: How are you going to implement these guidelines? How are you going to make sure that it actually happens within a particular home?

Hon Mr Clement: Mary Kardos Burton can speak to our oversight mechanisms.

Ms Kardos Burton: Certainly, I can do that, Minister. Thank you. We talked earlier about the operator having the responsibility for ensuring that standards of care are throughout all of the homes. We also mentioned the change in the regulation in terms of the staff providing that care to people, and we also talked about why it was different and there wasn't a particular number of baths listed.

First of all, we have a compliance manual; we have manuals, we have standards. We talked earlier this morning—we have 427 standards. The way we will ensure that appropriate care is being met is through our compliance program, in which I think we've demonstrated that we have a very good record. We have our regional offices, which are responsible for the ongoing operations, which work with all of our long-term-care

facilities. We have regular reporting mechanisms. We have audits that are also done. We have a variety of mechanisms. The rationale for not having one versus five is, as we talked about earlier this morning, different people have different needs in terms of—

Hon Mr Clement: Right, and I should state for the record that according to these standards of care, an individual should be required to receive more than one bath per day. That's why we've got 42 full-time compliance advisors who are there for the oversight, as Mary Kardos Burton indicated.

Mr Gerretsen: Nobody disagrees with that, Minister.

Hon Mr Clement: I'm very glad to hear that.

Mr Gerretsen: We're talking about setting a minimum. Why would you not put in regulation at least a minimum set of standards? What was the thinking that went into getting rid of the minimum notion completely, realizing full well that some people need more than the minimum?

Hon Mr Clement: Our experience with standards of care is that there is a potential for minimums to become maximums. Really, what is at stake here is the appropriate standard of care that is required, that should be expected by the individual when they place their health in the hands of others. Therefore, our experience and the advice of those who know this sector extremely well—

Mr Gerretsen: Who are we talking about?

Hon Mr Clement: —to Minister Newman and myself is that better, tighter, more oversight is required—better results are received, I should say—if there is a standard of care that is explicit but is not reduced to mere numbers. Mere numbers sometimes lead to less comprehensive health care, not more comprehensive health care.

Ms Kardos Burton: If I could just add to what the minister said, it was a conscious decision to take an outcome-based approach. So it is the outcome that's required in terms of the individual and the quality of care.

Mr Gerretsen: Is that the same thought process you used in order to get rid of the 2.25 or 2.5 hours of nursing care that you took out of the regulations a few years ago? Is that the same sort of thought process that you went through?

Hon Mr Clement: I really can't speak to that.

Mr Gerretsen: Did you want to say anything to that, ma'am?

Ms Kardos Burton: I didn't take the 2.5 out of the regulations years ago, but we had that discussion earlier and we got advice that we should look at regulations on that, and I think we're looking at that. No decisions have been made in terms of how we will be dealing with that.

I understand your point in terms of, it was in regulation; it isn't now. That does not necessarily mean that the standard of care is worse, but we will certainly look at that situation.

Mr Gerretsen: With all due—

Hon Mr Clement: With your indulgence, Deputy Minister Hassen would like to just add something.

Mr Gerretsen: Welcome, Deputy.

Mr Phil Hassen: Thank you. Just a couple of points: I think we're assuming everyone is going to try not to care for these people. Really, we have a series of professionals. Part of the reasoning of the funding was to ensure good medical care. The medical people are there also to help provide that standard of care. These are professionals and they do have a responsibility to ensure good care to the facility as a whole. In addition to that we have the compliance officers who do go in, evaluate the situation, make sure there is a care plan for the residents as well. Finally, besides the compliance officers, there's accreditation. Almost every one of the facilities is accredited. That too sets some standards in place. So I really would say that there is an intention to try to ensure good quality care, and I think the staff deserve a lot of credit for the care they provide.

We all know that we are always assessing these standards and ensuring they're good standards, and having been on that side of the arena as well you always are trying to balance these things. But clearly you're trying to provide the best care for the patient or, in this case, the residents.

Mr Gerretsen: With all due respect, I think a lot of people would suggest that if at least you had some minimum defined standards rather than the loose verbiage and terminology that all sounds wonderful in theory, it would give the individuals much greater assurances than is currently the situation.

I'd like to turn to community care access centres for a minute. We haven't spoken about that at all. Minister, would you agree that generally speaking—and I think your vision even speaks to that—it is preferable for elderly people to stay in their own homes as long as possible?

Hon Mr Clement: Absolutely.

Mr Gerretsen: Then why is it that if somebody needs more than 14 hours of weekly community care somehow the community care access centres cannot give more than 14 hours of care to an individual in a home?

Hon Mr Clement: We've always had a community care system that was locally based, that would look at the different circumstances that were inherent in the needs of the individual communities. Certainly we have tried to maintain and support that. There has been quite substantial funding, as there should be. Since 15 years ago, I think there has been a 440% increase in funding. I think you would agree with me as well, Mr Gerretsen, that our notion of home care and of community care and what it can do has grown, and certainly our government has made that a priority in its funding. The answer is that in each individual case we let the local CCACs determine the appropriate level of care. We're responsible for funding overall, of course, as a government. We have a $128-per-capita funding level, which is the most generous in Canada. Those are 100% provincial dollars, incidentally—there's not a single dime or nickel or penny of federal money that goes into that—and we will continue to be leaders in that area.

Mr Gerretsen: Could you explain to me why—and this is on page 71 of your budget documents—in the community care access centres there's about $30 million—the estimates last year were for $1.169 billion and the interim actuals for $1.139 billion; in other words, a $30-million deficit or underspending. Particularly when most community care access centres were screaming for money, why did the ministry underspend by that amount of money?

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Hon Mr Clement: You raise a good point. The money was allocated and was not spent.

Mr Gerretsen: The money was allocated and not spent.

Hon Mr Clement: Yes. It was part of my budget and it was not spent by the CCACs. So you might want to ask your individual CCAC why they didn't spend the public's money that way.

Mr Gerretsen: They're not public boards any more. We've been trying to get that kind of information from them, but they're certainly not as accommodating in sharing information.

Hon Mr Clement: They are public boards, sir. I would put it to you that they are—by an order in council, by a publicly elected government—so that makes them a public board.

Mr Gerretsen: Will you ensure, then, that when a member asks a particular CCAC within their area of jurisdiction or within their riding to provide that member with the information along those lines, as far as budgets and expenditures are concerned, that those CCACs will be providing that information?

Hon Mr Clement: Certainly I think it's our intention—Minister Newman's and mine—to ensure that each board is publicly accountable to the public and should be accountable for the money they spend and how they spend it—absolutely.

Mr Gerretsen: And the public would include the MPPs who represent that area? So if they wanted certain bits of information, I can quote you from the records of this meeting as basically telling them that they should provide the local MPPs with that information if they require it and if they're asking for it.

Hon Mr Clement: Certainly you should be in no worse a position than any other member of the public. I can assure you of that.

Mr Gerretsen: Thank you. That's very comforting. I'm very glad to hear that.

Interjection.

Mr Gerretsen: Only one minute?

Just so I'm clear, the 14 hours per week maximum that an individual can receive is set by the ministry, or is it set by an individual CCAC?

Ms Kardos Burton: Individual CCACs actually assess the level of service that an individual needs. There are regulations in terms of service maximums, and we are in the process of actually reviewing those service maximums this fall. But they are reviewed and they're based on an individual's need for care.

Mr Gerretsen: Would you not agree, if somebody needed, let's say, 18 to 20 hours of care but could remain in their own home, but needed more care than the 14 hours you've set out in regulation or otherwise right now, that it would make a heck of a lot more sense to actually fund that money and allow that person to live in their own environment—most elderly people would like to continue to do so—rather than forcing that individual into in effect the long-term-care facility?

Hon Mr Clement: John, I would not agree with your characterization as you put it. There has to be a clinical assessment made. Of course we all want those who receive community care, including the elderly, to be as close to home as possible, in their homes as long as possible, for many reasons, moral as well as financial.

Having said that, at some point, clinically, you have to make the determination that however much we may wish for them to stay in that environment, it is not clinically advisable, nor does it achieve the best outcomes, in which case other institutional care, regrettably, has to be the option.

Mr Gerretsen: But if it was clinically advisable before you changed the hours—in other words, if somebody needs 15 hours of care, then all of a sudden it's no longer clinically advisable to in effect give them CCAC and they should be institutionalized.

Hon Mr Clement: I think we indicated that of course we're in the midst of reviewing some of these requirements. They are based on what we see as the best results for the population, for society. But of course we're reviewing those at this time.

The Chair: We're at the end of this round of questions. We now turn again to the third party and to Ms Martel.

Ms Martel: If I might just follow up on that, Minister: I point out to you that there are a number of families who are trying to keep their special-needs children at home who have suffered greatly because of this reduction. The Leatham family in London is one. They're not interested in having their daughter in an institution. The family could care for her at home and were getting the hours from the CCAC to do that. I know your staff are aware of that case and there are many others like that.

That is why the policy that's in place which has two hours per day, 14 hours a week, is just not on for families who are doing their best to keep their severely disabled children at home, for example.

In any event, I just wanted to go back to the standards of care and point out again why we're raising this. The PricewaterhouseCoopers study released in January 2001 showed there was a serious problem with respect to levels of care in this province. In terms of Ontario, when ranked against other Canadian, European and US jurisdictions, we ranked dead last in terms of the numbers of hours of nursing care for residents in long-term-care facilities, the number of hours to intervene with patients who present with behavioural problems and the number of people who require rehabilitation. That's not our study; that was funded by your ministry, and clearly it

shows why, I believe, there need to be regulated standards of care—regulated, in regulation.

Hon Mr Clement: I can assure you we have that.

Ms Martel: You don't. It was your government that did away with the regulation that said residents would get 2.25 hours of hands-on care per day—your government. That is a fact. It might not have been you, but it was certainly your government. The problem is that now under you there certainly is a change with respect to bathing. We got from the library the reg changes over the lunch hour, and I don't know why you're making the changes that you are.

This is the old regulation. Section 8 says, "The nursing staff shall ensure that residents who are confined to bed or who are incontinent have a complete bath daily, or more frequently where necessary, to maintain cleanliness and that ambulant residents have a complete bath at least once a week." Section 9 says, "The nursing staff shall ensure that proper and sufficient care of each resident's body is provided to safeguard the resident's health and to maintain personal hygiene."

The new reg only includes that section 9, which says, "The nursing staff shall ensure that proper and sufficient care of each resident's body is provided to safeguard the resident's health and to maintain personal hygiene"—the exact same wording, except what the ministry did was drop the section that actually put in some numbers. I think that's wrong. I think that lets some facilities off the hook to say, "We don't even have to do the minimum any more that used to be in the regulation."

Hon Mr Clement: I could not disagree with you more. I believe that this regulation is a way to express a standard of care which is not reduced to mere numbers, that is produced on the outcomes that we expect out of the system that we entrust our elderly and others to. It is a way to express that a standard of care has to be assessed daily, has to be assessed professionally, and you cannot be let off the hook because of a numerical standard found in a regulation. If that numerical standard found in a regulation does not produce quality care, we have a problem with that.

Ms Martel: I think that the experience coming out of the PricewaterhouseCoopers study shows us exactly why we need minimum standards of care in legislation—exactly why—and you're going in the opposite direction.

Hon Mr Clement: We have 25% more compliance officers, and oversight is certainly better than it was 10 or 15 years ago. That's certainly been our record.

Ms Martel: If I might, with the nurse practitioners, you said you were going to double the number, and the base you're working from is 289. So there will be another 289 nurse practitioners hired. Is that going to be funding for permanent positions?

Hon Mr Clement: This is part of the operational budget of the Ministry of Health, so yes.

Ms Martel: When can we expect an announcement?

Hon Mr Clement: I'm sure you'll be hearing about it soon enough.

Ms Martel: I hope it is soon, because there are a whole lot of nurse practitioners who are underemployed or not employed whose services we could really use, especially in a lot of the underserviced areas in my community.

Let me go back to the MRIs. Minister, I would really make a specific request of your ministry to provide this committee with some more specifics about the breakdown of the $28.3 million. I would really like to know, and I think we should be able to know, how many new procedures will actually take place in the hospital system as a result of that funding. I would really like to know the breakdown between your just reimbursing hospitals for having to reallocate budgets in order to do procedures versus actual new procedures that will take place. If your staff could do some work on that and provide it to this committee, I think that would be great.

Flowing from that, then, the RFP is not out. Can you tell the committee when it will be out for the new MRIs and the CAT scans?

Hon Mr Clement: No, I can't.

Ms Martel: Can you give us an indication of what kind of potential funding you envision for the clinics in terms of operating dollars?

Hon Mr Clement: I feel a bit constrained, and I hope you'll understand the constraint, because we do not wish to give commercial advantage or other advantage to one bidder or another bidder. So I am restrained on what sort of information I can provide to you until it is part and parcel of an RFP.

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Ms Martel: Can you confirm the ministry will only be providing operating dollars and not capital funding for the for-profit MRI clinics?

Hon Mr Clement: I'm really constrained. Of course, when the RFPs are issued it'll be a matter of public record.

Ms Martel: Wow. So can I ask this question another way? Are you actually considering providing capital funds for this?

Hon Mr Clement: There are simple answers to a lot of these questions, but I'm erring on the side of caution in the sense that these are commercial bidding processes where we want the highest possible standards of rectitude to be part of the government process. So I really feel constrained until the RFP comes out, when I'm sure we can have a fulsome discussion about how it is framed.

Ms Martel: Maybe I'll make this comment. You already know New Democrats have been opposed to this proposal. I was very concerned when you and your ministry allowed some of that federal capital funding, technology funding, to go to for-profit centres, nursing homes etc. We would be absolutely opposed if you were actually going to provide capital money to for-profit MRI clinics as well through part of this—

Hon Mr Clement: I'll certainly take that under advisement. I think you're jumping to some conclusions, so we'll take it under advisement.

Ms Martel: But I don't know, because you've already given us an example with respect to the federal money. You had $380 million. It was clear that a portion of that, about $60 million, went to for-profit operations, be they long-term-care facilities or independent health facilities, to buy equipment. Is that not correct?

Hon Mr Clement: I would not jump to conclusions.

Ms Martel: Is that not correct that you already did that with respect to the federal allocation of $380 million?

Hon Mr Clement: The answer to that question more broadly is yes. We were concerned about the quality of care and the type of equipment used that is part of our public funding. It is part of our public funding when an X-ray diagnostic clinic performs a medically necessary service. It's part of our funding when a commercial long-term-care facility cares for our seniors. So they are part of the public sector too. Like it or not—

Ms Martel: Minister, only Ontario provided this money to for-profit institutions.

Hon Mr Clement: —when they take public money they are part of our public expectations. I see nothing wrong with ensuring that higher-quality, better-accessible medical equipment is available as part of our public system, quite frankly.

Ms Martel: I wonder if you can table for the committee the allocation that was made for the two years of the federal funding? Could we get an indication of which facilities were—

Hon Mr Clement: It's on the Web site, I think.

Ms Martel: For the two years?

Hon Mr Clement: Yes. It's on our Web site.

Ms Martel: If I just might point out again, I think, Minister, only Ontario actually provided federal funds to for-profit clinics. No other province did that. It was not part of the package.

Hon Mr Clement: You know what? Sometimes we're ahead of everybody else.

Ms Martel: We have a different view about that on that issue. We remain very concerned about two things. Number one, you told the health ministers that you had evidence that this privatization would work but you also said that the MRI clinics will only be allowed in the province if the private firms show they could provide cheaper and better diagnostic treatment. Can I ask how you intend to go about proving—

Hon Mr Clement: No, I said better, cheaper, faster, safer.

Ms Martel: How do you intend to go about proving that and showing that?

Hon Mr Clement: That is why one has an RFP, so that we can compare how the commercial sector can provide services, greater accessibility, within a universally accessible, publicly funded system for the medically necessary services that our citizens expect to have quicker and closer to home, and if they can so evidence that, then we go ahead. Right now in this province there are hundreds of facilities, a thousand facilities, under the Independent Health Facilities Act, which was created by a Liberal government and implemented by an NDP government, a thousand private clinics within a universally accessible, publicly funded system. We have X-ray clinics right now approved by your government providing services, but they can't do a CT scan and they can't do an MRI scan.

Ms Martel: So the answer is that you can't provide us the criteria about how they're going to show they can do it faster, cheaper and safer until the RFP is out? Is that the answer?

Hon Mr Clement: That's inherent in our expectation, and certainly we will be setting standards that will be a part of this process and will frame the expectations of our government to ensure that we have better, more accessible diagnostic procedures closer to a person's expectation of when they receive those kinds of services.

Ms Martel: Can I ask how the ministry is going to prevent queue jumping?

Hon Mr Clement: I think I indicated that certainly part of the standards and expectations that we set will involve that medically necessary services will always be provided without additional charges, co-payments or fees. That is a requirement of the Canada Health Act. We intend to be absolutely consistent with the Canada Health Act. As in the case right now, if an independent health facility right now in some way deviates from standards and expectations, we can and we have and we would pull the licence. We'd pull the licence.

Ms Martel: It's the College of Physicians and Surgeons that does the assessment, right? Do they also monitor the compliance with respect to that very issue?

Hon Mr Clement: Again, the short answer is that we will have a regime in place to make sure that all of our standards and expectations in compliance issues will be met by any successful bidders.

Ms Martel: Does that include increasing inspection staff?

Hon Mr Clement: If necessary, yes.

Ms Martel: Has that been allocated for in the estimates? It hasn't on the long-term-care side.

Hon Mr Clement: Certainly we have staffing needs, but as we roll this out, we will be assessing that very carefully.

Ms Martel: Let me ask you if I can have some information tabled by the chief nursing officer. You can stay there, if you want, Ms Valentine. I'm actually interested in some of the nursing numbers of Ontario graduates. I'm wondering if the number of RNs who graduated beginning in 2000 and 2001 can be tabled for us. Can you give us some projections up to 2004? The reason I'm using 2004 is that in January 2000, the government made an allocation of additional funds and projected that there would be 2,800 nurses graduating at that time. I wonder if the government is still on track with that projection.

Ms Valentine: I'll get that information to the extent that I can.

Ms Martel: The second question would be, because there was a budget announcement of $50 million by 2005-06 for nursing education, whether or not that

changes any target, or are you still working with a target of about 2,800?

Hon Mr Clement: You're getting into the territory of the Ministry of Training, Colleges and Universities. We might have to write a letter to Dianne Cunningham about that.

Ms Martel: But if you have a chief nursing officer and an office dealing with nursing issues, do you not have access to that? Do you not track those things as well?

Ms Valentine: We'd collaborate with the Ministry of Training, Colleges and Universities, but it's not the type of information that I would have readily available within my office.

Ms Martel: If you could get it, that would be great.

I just have one other question. This has to do with the nursing advisory committee's final report to the ministers of health, because they recommended increasing the number of first-year seats in nursing schools by 25% in September 2004, and then there were increases in each of the next four years. I'm not sure, Minister, if you're in a position to comment on what Ontario's position would be with respect to that important work, which clearly outlines that there is a shortage and we need to deal with that.

Hon Mr Clement: Certainly it was a topic of discussion among myself and my colleagues at the provincial-territorial-federal meeting. We discussed that very report. I can tell you that I was able to communicate to them the great strides that the province of Ontario has achieved. Of course, not only do we have the highest-paid nurses in the country but we have seen great strides in recruitment and retention—the 12,000 positions that we fund through the $375-million annual fund is part of that—and we're working collaboratively with the RNAO and other institutions for recruitment, retention and education issues. So that was the kind of information I shared with them.

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This might be of help to you. We talked about more of a pan-Canadian strategy on health human resources, not just nurses but including nurses. There was certainly some appetite for greater collaboration on those issues, working with the federal government to match needs with the supply of new individuals who would be capable of being part of that medical profession.

Ms Martel: Do you anticipate that Ontario is going to have to change some of its funding strategies if you're actually going to try to implement portions of the report?

Hon Mr Clement: I think we're actually quite far ahead of the other provinces in this regard, so I think others are looking to us for leadership, and we've been providing that leadership.

Ms Martel: I wanted to talk about primary health care reform. I was at your press conference yesterday, and I just think it's fair to say that you and I have a different version of what "trailblazing" means.

I've got to tell you, Minister, I don't know why you want to try to continue to resuscitate family health networks. It has been over two years now since the contract was signed with the OMA about the scope and the framework. We're now in a position where we have 40 new physicians who are part of this process, and in reality what you have is a bit of a change in terms of funding but essentially physician-only practices. I think if you are trying to advocate for real primary health care reform, you need to just admit that this project has not taken you down the road very far very fast.

I think what you should really do is to now actually fund the proposal that has been put to you over two years ago by the Association of Ontario Health Centres to actually start to get new CHCs up and running and to expand existing ones. I know you had a meeting with Gary O'Connor a couple of weeks ago. I know there was a very glowing result with respect to the importance of CHCs and how well they work from the strategic review that was finally released this year. I don't understand why you are not putting your government's or your ministry's time and energy into expanding the existing network of CHCs and increasing those rather than spending one moment more on family health networks. They are not taking you where we need to go.

Hon Mr Clement: I really couldn't disagree with you more. You mentioned a two-year time frame. It was only this January when we had the final contractual template so that people could actually sign up. As I said, there have been over 700 consultations, detailed dollars-and-cents consultations with family physicians who are eager to sign up and do the final calculations that they need to do to shift over their practice. So I remain incredibly optimistic, and I think my optimism is based on evidence that we are proceeding.

You mentioned the community health centres. Let me state for the record, as I stated to the organization several weeks ago, that community health centres are an integral element of primary care and will be in the future. I foresee an expansion of them as part of the solution. They are not the only solution nor are family health networks the only solution. In some cases, community health centres make more sense in the traditional form; in many cases, FHNs make more sense.

My attitude is: let a hundred flowers bloom. Let's let all of these different elements of primary care work and work well, and they will all be part of a very successful implementation, in my estimation.

Ms Martel: Do I still have time, Chair?

The Chair: Your time is up. Now I'll turn to the government caucus.

Mr O'Toole: We'll be dividing our time again.

I'll just pick up on the same theme here. I, again, always have the first interest of my constituents at heart. As you know, in Durham—I've sent you correspondence with respect to one community—the Scugog or Port Perry area is in the process of defining itself as underserviced. I'm assured that the Bowmanville site for Lakeridge is also in the process. They were previously excluded because they were part of the greater Toronto area. I see that some of the things you've been talking about, the family health networks and other kinds of

community health organizations, will go a long way to providing, along with the nurse practitioner issue.

I'm part of a physician recruitment team as a sort of observer. I have to pay compliments to Ted Griffen and Dr Cohoon and members on that committee I've been working with.

One of the things that came up out of it—this isn't directly a question or a criticism; it's more of a clarification and I'll probably air my own view just to sort of let you know where I'm coming from. They're talking about physician recruitment and I keep telling them what you said in your opening remarks: this isn't an Ontario problem; this is a Canadian problem. Indeed, arguably, it's an international problem—commonness and standards and that. But the physician recruitment committee, in my understanding, is going about raising funds to offer new interns or new doctors some sort of stimulus or encouragement to the tune of maybe a free car rental or something like that. What I'm hearing back outside the meetings from the existing group is, "What about us? We'll just go and do locums and shop around and never set up shop."

I know you've wrestled with it; I know you've opened and got plans to open and expand existing training and foreign training. Could you give us a bit of your own pur-??view? My view, as I said, on this stimulus or encouragement is it's the wrong place to start. If we start boxing in existing physicians and only topping up the new ones with a free rental on a house or a car—and the bottom line is they're really stealing them from some other community. If they recruit them from Stratford or Norwood, what's the resolve here? They're then going to have to go through the same process.

I know it's complicated—the family health network, the group practice, adding nurses and other health care workers. Perhaps you could just give us some glimpse of how far away we are with the northern medical school and those solutions, the longer-term solutions. I'm sure it's something you want to solve as quickly as possible, but, being honest, what you said earlier, it's a problem in other provinces. I've seen CBC reports where half the doctors in BC are from South Africa, and here it is: South Africa is now short of doctors. It's a huge challenge and it's complex solutions.

Hon Mr Clement: I think you've very successfully indicated some of the key points in this discussion. You just mentioned South Africa, which is facing an AIDS pandemic, and various jurisdictions are encouraging South African doctors to leave there and come here. There are some moral issues that are imbedded in that. I think George Zegarac is eager, chomping at the bit, to talk about this but let me just put my overlay on it first and say of course it's a multifaceted problem which requires a multifaceted solution. Part of it is the financial incentives, part of it is the expansion of the pool which is through the medical schools of course and through IMAs of course, and part of it is alternative payment plans in all of their guises and definitions for existing doctors to retain them so that it's not just recruitment; it's retention, which means longer-term solutions rather than just grab the doctor, make her set up shop and then you're OK. She's got to have an incentive to stay there, which requires longer-term solutions. So through the George and McKendry investigations we've had a whole series of recommendations. As it turns out, this is what the public is concerned about. I always think of, Lyn McLeod would be happy to know, when I was talking to my provincial and territorial colleagues I mentioned the case of Thunder Bay: you know, a successful northern community of approximately 130,000 people, 40,000 people without a family doctor. Not good enough. How is Thunder Bay going to attract new business, new opportunity, new economic success when the first question the employer or the start-up entrepreneur is going to ask is, "Who's my family doctor?" So we've got a ways to go.

These problems were 10, 15, 20 years in the making. Some of these things will take several years to assist us, but things like IMGs can assist us right now and that is why we're taking this multifaceted approach.

George, I hope I haven't stolen your thunder.

Mr George Zegarac: No, that's fine.

Hon Mr Clement: The assistant deputy minister of integrated policy and planning division.

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Mr Zegarac: Thank you, Minister. As the minister indicated in his earlier remarks, the government over the last two or three years has taken a comprehensive approach, and that's the only way we're going to address these issues because it really will take a multifaceted approach to deal with some short-term pressures and some long-term pressures.

Dr McKendry, who is our fact-finder, reported to the government back in December 1999, and that government responded immediately and took some short-term measures: increasing the undergraduate enrolment by 40 positions immediately; moving forward with and expanding international medical graduate positions, moving forward with expanding opportunities for repatriating Canadian medical school graduates who were training in the US and who would like to come back but require some additional training. So we provided funding for that. We doubled the number of community development officers. We expanded our re-entry program. Those were short-term measures.

Part of that response was also to commission the expert panel that Dr Peter George from McMaster led. They reported back in 2001, and again we had to look at longer-term solutions that were going to be much more comprehensive in nature.

The enrolment increase: actually, the recommendation by the expert panel was to increase by 30% over a three-year period. The government response—and as the minister said today, we actually delivered within a two-year period. So the faculties of medicine have been working with us to actually go beyond the expert panel response and try to address the real pressures that we're facing right now and to try to create some longer-term capacity. It's not just capacity immediately, but develop-

ing—and I'll get to the post-grads that have been allocated to the north, because even though we don't have the northern medical school up and running yet—the commitment was 2004—we have allocated over 30 post-grad positions to Thunder Bay and Sudbury to start to build capacity and training, providing service to the communities, and those, quite frankly, will be some of the preceptors that will support the northern medical school as it gets established. So this is the capacity-building.

As the committee member indicated, in the southwest this is a challenge we're having as well. Fortunately in the north we had two well-established programs we have built on that have good relationships with McMaster and Ottawa University and we've been able to build that type of infrastructure. We hope to do the same—I am in constant dialogue with London and with Windsor and we are, I hope, very close to resolving any outstanding issues around their operational plan they're going to be submitting. We hope to be able to have the capacity in the southwest. The government has funded those positions.

We have funded positions also in the rural network that's covering the Niagara region, the Collingwood-Simcoe area. But we also realize that physicians aren't going to solve all the issues. The minister has already identified that we are going to have to look at other available resources to complement that.

The Nursing Task Force: as the chief nursing officer has identified in our response back in 1999 to the Nursing Task Force response, we introduced 106 nurse practitioners in underserviced communities. As the committee member has indicated, that's a huge opportunity in those communities. But we also—and this addresses one of the earlier questions about long-term care—introduced 20 nurse practitioners in long-term-care settings as a pilot that has been successful and that we hope to be able to build on.

This is a challenge. The government has made a number of commitments. It has its free tuition program that's geared to encourage new graduates to practise in underserviced communities. We have also looked at building on those opportunities with foreign-trained physicians. We have more than tripled our capacity to deliver both training and assessment of foreign-trained physicians. Under McKendry, we increased our physicians by 50% for the Ontario international medical graduate program here in Ontario, but we also responded with a new program to be able to try to accelerate the registration and licensing of physicians here in Ontario through the assessment program for the international medical graduates. We allocated 40 positions. The faculties have been working diligently with us. They actually delivered the additional 14 positions in the OIMG program a year ahead of schedule, so that was great. They have worked with us to develop the assessment modules for a number of different specialties, and we hope to be able to fill all 40 positions by the end of the year.

So if the work is not done, as the minister said, we're having discussions with our partners on the IMG issues and looking at further expanding on the opportunities that we've already taken advantage of. But it will have to be a comprehensive approach and it will have to also be a national approach.

Mr O'Toole: We just hope they all stay in Ontario at the end.

I think Mr Chudleigh has a question on that area.

Mr Chudleigh: Speaking of the nurses, who are the most valuable part of our health care system, I wanted to ask you a question on the flu shot program, which nurses by and large, I think, deliver.

I'm aware that we have this extensive program and that we're one of the few jurisdictions in Canada or perhaps North America that has a flu shot program that is comprehensive to the entire population of Ontario.

I was wondering, Minister, if you have any numbers on what percentage of the people of Ontario have received that flu shot, first of all. Secondly, have you done any work as to what that flu shot costs and what money it saves in health care costs and also saves in workdays not lost and those kinds of things? Are there any estimates done in those kinds of areas? Does the program produce a net benefit overall?

Hon Mr Clement: I would ask Dr Kurji to briefly outline—

Mr Chudleigh: He answered my last question. Will there be tests after this one too?

Hon Mr Clement: The statistics that I'm aware of—maybe there are some from last year's campaign—in the ones two years ago, the incidence of flu in our society was half of what was expected when you compare us to other provinces, firstly.

Secondly, another statistic that I embedded in my brain was that the incidence of flu in our nursing homes, our long-term-care facilities, declined by 97% in the first year of the program, which means that they're not going to the hospital. Those people, because of their condition, were more likely to go to the hospital, more likely to go to ERs. So we were definitely diverting people away from that.

If I can allow you in 25 words or less to elaborate on that, it would be great.

Dr Kurji: For the last year of the flu program, there were six million vaccines ordered and, of these, about 5.14 million were sent to health units. Some of these orders were then cancelled, so the net distributed was 4.9 million doses. So those are the numbers that have actually been distributed and have actually been administered to the population.

With respect to the evaluation of the program, basically, I think it would be fair to say that it is a little early to make great decisions with regard to final conclusions, because the flu activity tends to vary from year to year. The very first year that we had the program, as the minister has indicated, we had a tremendous decline in the numbers of nursing home outbreaks, long-term-care institution outbreaks. The following year we weren't so

lucky, and we actually had a rise in the numbers. Nevertheless, these numbers were still lower than what we would have expected.

As the minister has correctly pointed out, certainly the impression is that we are making great headway with regard to averting flu-related diseases and complications.

I think I shall stop there for the moment.

Mr Mazzilli: I just want to thank you for the capital funding that was allocated to London. Certainly the South Street campus, as you've heard, was closed by David Peterson 15 years ago, but of course the capital money never came to rebuild it. So I want to thank you for that.

Some of the prevention that you and some of your staff talked about—and I'm always skeptical because I don't know what to do. We all know that prevention is something that should be done, but how do you achieve it without spending an enormous amount of money trying to educate people? And then, really, you don't know whether you will ever see the benefits of it or if the strategies are working. Can you explain some of the strategies that your ministry is working on?

Hon Mr Clement: Sure. There are certainly elements of a great number of our programs that you could characterize as prevention and disease avoidance. For instance, when I look at our stroke strategy, our asthma strategy and our Alzheimer's strategy, all three of them—which are incidentally, again, trailblazers in North America for their progressiveness in dealing with some of these issues—have an early detection education component for individuals like health care providers and others so they can detect early signs of Alzheimer's or early signs of stroke or what have you. All of the evidence indicates that if you can detect these things early and intervene early, the impacts on the individual are a lot less severe. So I would characterize that as part of our prevention strategy.

I think your question was broader than that and was into some of the wellness issues. Of course the biggest disease prevention campaign we can do is convince someone not to smoke. I'm looking at you when I say that; I don't know why.

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Mr Mazzilli: I know that you are, and there's been a lot of money spent on people like me, trying to convince me not to smoke. And that's where I wish you luck in your prevention—

Hon Mr Clement: We just released a report from the health ministers' meeting that indicated that smoking in Canada is at its lowest level since 1965. So there are some indices that indicate some progress. There is more progress to be made, and certainly we believe there can be a very aggressive strategy similar to ones that have been tried in other jurisdictions, like California and Massachusetts, that especially can work on the juvenile element of smoking.

I'm very proud of what we call the youth tobacco team, which I employed. A group of youths came together from all over the province, demographically diverse and so on, and put forward a series of recommendations that I'm very proud of that will help us re-examine our tobacco strategy for juveniles.

We have 200,000 juveniles who smoke right now, and if there's any dip in that, it's only because they're smoking pot instead, after reading the Senate report. But in all seriousness, this is a health and public health issue that we have to tackle. So that's part of public health.

Then we've got obesity.

The Chair: Two-minute warning.

Hon Mr Clement: Thank you.

We've got issues of obesity. Type 2 diabetes, acquired diabetes, is rampant in our society, especially amongst young people. This shows a failure of us as a society to successfully transmit to younger people a proper healthy lifestyle in terms of both diet and exercise. Not acceptable. This is an area where we have a little bit going on right now, not enough. Certainly it's an area that, with my provincial and territorial and federal colleagues, we're intending to have a more overarching strategy. So if anybody around this table has any suggestions on that area, by all means it has to be a focus in the future.

Mr Mazzilli: Well, good luck with your initiatives. I'll pass it on to my colleagues.

Mr Miller: I'll wait for the next session.

The Chair: OK. Thirty seconds. Any comment?

Mr Mazzilli: Certainly. I'll keep going. I know in 1997 the federal Liberals campaigned on a national pharmacare program. Is there any movement along that line that they're going to keep that promise?

Hon Mr Clement: I haven't seen any so far.

The Chair: We now turn to the official opposition and Mrs Pupatello.

Mrs Pupatello: I just wanted to remind the minister that one of his cabinet colleagues was the one, in discussion of pot smoking, who said he never exhaled. So I think if we start with cabinet in the Ontario Conservative government, we might eradicate that there first.

I wanted to go back to your OHIP expert. I don't know if you'll call him into the bullpen, because I do have some questions for the OHIP group again.

Hon Mr Clement: Yes. Dr McCutcheon, I believe.

Mrs Pupatello: While he's coming, I might ask you about community health centres. We understand there are some 100 communities in Ontario that are waiting for and wanting community health centres. A little while ago, you referenced a report that you received that had glowing terms for what good work community health centres do in the communities. It was well known that these groups haven't seen any kind of increase in the last 10 years in relation to salary or any kind of compensation and benefits. That is becoming a huge issue in terms of the retention of staff.

Page 111 of your estimates is showing $740,000 as the increase, out of $117 million, going toward health centres. Page 112 shows funding increases of $830,000. So I understand what the amount is. Has that been targeted to anything in particular—to a particular health centre—or

spread across the ones we have? Why wouldn't you have allowed for additional, considering you had that report that you commissioned for over a year before you released it? We assumed you were sitting on that report to give you time to get money in that budget line.

Hon Mr Clement: Let me state generally, as we get the appropriate official in place, that I'm very supportive of the work the community health centres do. They're certainly part of our primary care model, and should be. And certainly the report you referenced was helpful in understanding the appropriate role they could play. So in my meetings with the association that represents community health centres, we are devising proposals and plans and strategies that would move us forward in this regard.

Mrs Pupatello: Is there a reason you didn't allocate more funding for community health centres, given how wonderful you think they are?

Hon Mr Clement: The approach has been to work out some details with the community, and I understand their concern over levels of funding.

Mrs Pupatello: Sorry. Which community?

Hon Mr Clement: With the community health centres association, the association that represents the community of community health centres, if I could use that term, in our province. Certainly we are working on a way to move forward.

Mrs Pupatello: Minister, are you aware that you've got several proposals that have already gone forward and are in various stages of the phases required to get approval? You have many well on their way, literally ready to set up shop and just waiting for your approval, and many of these are in underserviced areas?

Hon Mr Clement: Certainly I'm aware—all members of the House are quite adept at making me aware—of those proposals, and there is a lot of merit that is to be found in those proposals. I'm very supportive of community health centres. I think they have an appropriate and important role to play in primary care and that they are part of the strategy we are employing.

Mrs Pupatello: How do we differentiate this glowing report you're giving them and your continued support—how do we marry that with your not putting more money in that budget line this year for more community health centres? We appreciate—I know they do—hearing you say how wonderful they are, but it's like giving them the sleeves of your vest. If you don't put money in the budget for them, you may as well tell them to go home. We've got 100 communities waiting for them, many who have already gone through the machinations of the proposal writing, various phases of those proposals, various levels of acceptance etc. They are essentially waiting for you to give them the money.

Hon Mr Clement: Certainly I will take your concerns under advisement. They're very important.

Mrs Pupatello: OK. Could I ask the gentlemen who is your guru on OHIP: I was curious to know what precedents the OHIP offices have in striking group rates with American facilities for services for Ontario residents.

Dr McCutcheon: Generally, we don't strike group rates as such, but we reimburse based on out-of-country submissions that are made to us.

Mrs Pupatello: Many of the HMOs or places that our patients are being sent to in the US are private companies. Many of these have group rates. For example, if they know they're going to get 10 patients with the same procedure, they'll likely get you a better deal for 10 as opposed to one. So when Cancer Care Ontario came out with a report two years ago that was showing alarming numbers of patients going to Buffalo, Detroit etc, at some point did you have any discussions with those facilities to get the best price for the Ontario taxpayer?

Dr McCutcheon: I personally don't know, but I can certainly find out what was done at the time. I can tell you that the amount of money that was spent out of country for cancer care has gone from $16.9 million in the year 2001 down to $9.2 million in this past year. That's a reflection of the program to retrieve radiation therapy services back to Ontario. So it's fallen from $16 million to $9.2 million.

Mrs Pupatello: Was it your department that tipped off the ministry that they ought to be putting more services in Ontario because the payments you were making out of country were alarmingly high?

Dr McCutcheon: I don't know the answer to that at the moment. I wasn't in the position at the time this occurred, so I'd have to find that out.

Hon Mr Clement: There was a lot happening then.

Mrs Pupatello: When you were here earlier, you reported that certainly your office or your department puts out the red flag, that you have various people who review things to look at sudden spikes in certain types of payments.

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Dr McCutcheon: We look at things such as gamma knife technology and these kinds of things. We're looking at trends and seeing what are some of the developments that we need to look at from Ontario's perspective.

Mrs Pupatello: Specifically, the medical side of people giving approvals: many of our MPP offices work with the Kingston office and then they divert to the various regional medical people to make determinations. On many occasions we've tried to get out-of-country coverage for a variety of things, and we've had some precedent-setting things like a consultation for a specialist, for want of specialists where I come from; we've had approvals for them because they don't exist.

But sometimes it's almost as if your office is coy with us because you're afraid to set too much of a precedent for the political message that it might infer. For example, why would your department refuse out-of-country coverage for family doctors, knowing that most of Ontario is underserviced, that you can't find a family doctor here? Whatever the government is currently doing to try to improve that situation is light years away from actually having an effect. The professional bodies agree that the solution or even any kind of inkling of a solution is a long time away, despite what activity was just recited for

us a moment ago. Why wouldn't OHIP cover out of country for family doctors?

Dr McCutcheon: I think the strategy that your government is taking is primary care reform strategy to increase accessibility to family doctors. The Telehealth project, the various other strategies in place at the moment obviate the need to look at that as an alternative.

Mrs Pupatello: So are you making a medical decision that Telehealth is actually better than having a family doctor do a personal visit?

Dr McCutcheon: No. I'm saying that putting in place the HSOs, the primary care networks and the family health networks, having 24/7 availability and having other strategies coming forward, such as multi-disciplinary strategies etc, really is a much better way to go about providing primary care within the province.

Mrs Pupatello: I think that if your department had to submit your report card to the minister and you showed a 3.47% success rate, likely the entire department would be removed post-haste from the government. That in fact is the amount of doctors who are currently participating in primary care reform. I can't imagine that another department could use this government's snail pace in primary care reform as some kind of "hang your hat" to not allow family doctors in terms of out-of-country coverage. You can't possibly imagine that we would wait for primary care reform to solve our family doctor crises across the province. You can't use that excuse.

Only 3.4% exist in Ontario. While the minister calls that trailblazing, I need him to raise the bar in our expectations for primary care reform. It is virtually negligible in terms of what impact it's had on family doctor care. I need to impress upon the ministry that all the ministries have to work together across the board to solve the problem.

The minister's response that they've improved, these new 40 spots for IMGs—we asked questions of the ministry, and the information we got back is that in fact there aren't 40 more, there are only 27, and those 27 don't include family physicians because other places in the world don't have the two-year residency for family doctors. So those aren't the types we're getting for IMGs anyway.

Just moving into this other area of questioning for the minister, foreign-trained physicians seems to be the one way you can have an immediate, lasting blast of an impact in terms of physicians' availability for people in Ontario. We've repeated this time and time again. When you came out with this new and improved process to be streamlined, in essence it hasn't improved. The same barriers that existed for these foreign-trained physicians still exist today.

The requirement to have practised in the recent past is almost impossible for most of these foreign-trained physicians. These are people who have been in the midst of leaving their country, travelling to come to Canada, mired in various bureaucratic red tape to become citizens or not, and this is the same time frame that you're asking them to list when they've practised in Ontario. That's why they can't continue in the application process. The minister's office is aware of these hurdles and really it's been frustrating to see, just constantly hitting the same wall. You knew what the hurdles were; we brought people with very little notice, we filled a room, 100 people, with two days' notice to meet your staff, Minister, to tell you why they can't get through your process, even this new, improved process.

You've got to give us an answer. I made a series of recommendations, one being an amnesty period where you would have temporary licensure as exists in other parts of the nation. This is a national problem, as has been referenced. We're losing doctors to other provinces for a whole variety of reasons, and there are people who have been trained in Michigan and who are practising in other provinces in this country under a temporary licence. I don't know who's saying that New Brunswick people—what, do they have a lower standard than we have? I think we have a national standard of health care. Why have we not adopted a temporary licensure program similar to other provinces?

It's not good enough to tell me 40, because you haven't reached 40; you've reached 27. The OMA submitted a report to you and the OMA looked at all that you've done and they said, "We observe that the incremental expected positive impact is fairly modest overall," in terms of what you've done to improve the doctor numbers in Ontario, "and no impact is expected until 2008." We are so short-staffed in most places in this province, you can't possibly expect us to wait until 2008 so maybe you'll find some doctors in Windsor who are prepared to train these new rural training centre students who are coming out. On average our family doctors have 4,000 patients on their client load, Minister. So you come in to talk to them about primary care reform; you'll be lucky if you wait a couple of hours and maybe they'll have a conversation with you while they're having a hotdog for lunch. They don't have this kind of time. I don't think we're being realistic about what we're asking them to do.

I can't impress upon you enough that you've said a lot about what you're doing to improve the doctor situation in Ontario. The results are very slow. They're negligible in the end in terms of what you've announced. The long-term strategy will not see results till 2008, and you have an immediate opportunity with 1,500 foreign-trained physicians in Ontario—that figure comes from your office—something that you can do immediately and have an immediate impact. And the best we got out of you was, "We're going to improve the assessment program and we're opening the spots to 40." Forty were not filled and the new assessment is not working. So I'm hoping to get some kind of comment from you that might be positive and at least endeavour to review other opportunities that come your way by virtue of temporary licensure, some kind of an amnesty period where these people will be accepted while you sort out a new system.

Hon Mr Clement: I certainly thank you for your commentary. I've heard elements of it before and I thank

you for reminding me of your position on these issues. George Zegarac can get into the detail of the current program, 27 versus 40 and whatnot, but the Ernie Eves government's position on this is quite clear: we expect to have more international medical graduates as part of our system; we are not satisfied with the current processes in place by the certification organizations, which are not the Ontario government, I might add, as the honourable member well knows; and we expect change to occur.

Mrs Pupatello: Minister, can you clarify something for me, just while you're mentioning that. You in fact, as the Ontario government, regulate the college. You set the mandates, you write the regulations, and they exist by virtue of Ontario legislation. Is that correct?

Hon Mr Clement: Mrs Pupatello, that is a simplistic conclusion.

Mrs Pupatello: But they do exist by way of your legislation, Minister.

Hon Mr Clement: Yes, they do.

Mrs Pupatello: Yes, they do.

Hon Mr Clement: But they exist as self-regulating professions, as you well know, and they exist as being responsible for their own certification, as you well know. So, yes, they are creatures of legislation, but they are creatures of legislation with certain rights and responsibilities.

Having said that, I am not satisfied with the current situation, I'm not satisfied with the status quo, and certainly there will be changes.

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Mrs Pupatello: Minister, I guess I just need to tell you that we are into the eighth year of your government—eighth—so it's impossible for us to listen to what happened before. We have practically an entire new population of Canadians in the length of time you've been in office—and it feels a lot longer than eight most of the time, I might add. However, eight years is a long time for you to say, "We're working on this."

Hon Mr Clement: No, you said that. I didn't say that.

Mrs Pupatello: I'm telling you that since 1995, you have been aware of the international foreign-trained physicians issue in Ontario. In that amount of time, we have heard repeatedly that the government is working on it. All I can tell you is that if it in fact is a priority of the government, it will happen.

We understand that Ernie Eves as well has blamed the college and suggested that it's other arm's-length bodies—other arm's-length bodies such as what? School boards in Ontario that you've decided to take over when it's your will? You've sent supervisors into hospital boards.

When you choose to, Minister, you can have exactly the effect you want. In this case, I think you'll have all-party agreement that we insist on bringing in foreign-trained physicians to work in Ontario for immediate solutions to a problem in some underserviced communities. We're offering you these ideas. We understand that they're under review. Nothing happens. We believe that there are solutions that can happen quickly.

Hon Mr Clement: Mrs Pupatello, it is actually incorrect to say that nothing happens. A lot has happened over the last couple of years, in terms of expanding recruitment and retention initiatives. So I disagree with your assessment. It's your right to make that assessment as subjectively as you want to make it, but it's not accurate.

Mr Gerard Kennedy (Parkdale-High Park): Mr Clement, I just want to interject. I have a very brief time.

I want to ask you on behalf of a constituent—her name is Ellye Pryce. You would have noted in your clippings over the weekend that she's the woman who's not going to get hyperbaric chamber treatment because of the policy that you're allowing Toronto General to do.

I heard from Ms Stuart earlier that these so-called electives are not being reconsidered to be more available. They won't happen in Hamilton. They won't happen at all in Toronto for 15 months. I really want to check in with you on that.

This woman has had an operation. This hyperbaric treatment has helped immensely in her healing. I want to find out from you whether you're just dismissing that this woman and others require this hyperbaric treatment for other than emergency things, coming from the bends or from fire—although we can't dismiss those. Hamilton is a long way away in those emergencies.

I want to ask you: is the last word that we're going to have this shut down for 15 months or is your ministry actively reviewing the possibility of finding another way, whether it's at Toronto General or elsewhere, to continue that treatment? Because Ellye Pryce has a jaw that is coming apart. She literally could lose it if she doesn't heal properly. She deserves compassionate consideration. I understand, although I'm not an expert, despite a little bit of exposure to this—I certainly can't vouch for the fact that there are other people. In this case, I can vouch for her.

I wonder what you would say through me to her because, frankly, she has had her surgery today and she won't be able to speak for a little while, and she has other surgery that she needs consideration for. I'm wondering what you can tell her.

Hon Mr Clement: What I would like to say is that the ultimate responsibility of the government and the ministry is to ensure as best we can the health and safety of Ontarians. We review decisions that are in our purview to review, and we make decisions that are in our purview to make.

As I say, from my perspective, we constantly review any evidence or opinion or additional information that pertains to the individual decisions of individual boards of directors.

Mr Kennedy: Who can I talk to, Minister? Who is actively considering this particular situation that could affect—

Hon Mr Clement: I'm sure we can discuss it after this meeting. I'm not prepared to talk about an individual patient—

Mr Kennedy: All I want is one answer: is this particular decision being reviewed by your ministry or is it final that you will not intervene?

Hon Mr Clement: We will always look at new information, new evidence, new opinion, new experiences. We always do.

Ms Martel: I want to return to the matter of community health centres.

First I want to ask a question about this: on the estimates on page 100, the operating line for community health services where CHCs are included does include, of course, CHCs, midwifery and substance abuse. There appears to be an $8-million change. I am wondering if that is attached to the substance abuse part of those three components. Is that essentially what the change is?

Ms Ure: It's Gail Ure, executive director, health care programs. There is an annualization of the three community health centres that weren't fully annualized. Those were the last three: Grand Bend, one in Waterloo and another one. That was the completion of their annualization. Up till that time there had been fiscal dollars that had been used to supply their necessary funds. But in this year it was annualized.

Ms Martel: Then in that regard, because I followed up last time we were in health estimates in October and let me follow again, in my own community there is a French CHC that has, as of about July 15, I gather, submitted their capital plan for their two satellite sites to the ministry. I don't think that they have received a reply yet. I know I haven't received a reply to my correspondence to you, Minister, which was to support that particular application. I gather what is required here is some kind of approval from your office so that this might go forward. Can you tell me where this is, after many long years now, finally at?

Hon Mr Clement: Certainly we are in the process of formulating a new strategy when it comes to CHCs and certainly these are the kinds of individual decisions that will flow from that.

Ms Martel: Can you tell me when the review of their document might be done and they might get an answer?

Hon Mr Clement: As I said, we've decided on a path with the association representing the CHCs to work on some proposals and some ideas and we're in the midst of that right now. I wouldn't want to cut that short.

Ms Martel: Let me back up. This is one that has been under active consideration by the ministry. I apologize; I should give you some details again.

This was a CHC that had previously been funded. The ministry had made a commitment in November 1995 that at some point there would be funding allocated, over $1 million, for the two satellites and they had been working since then to do that. So my assumption has been that they are not included in the package of particular proposals that the association has given to you, that this actually has been moving along on its own so that the ministry could meet a commitment that it made in the fall of 1995.

Ms Ure: We're also discussing operating issues with them and some of the standards in the original agreement and that's been part of what is being discussed right now with them, as well as the capital.

Ms Martel: Can you tell me, Gail, when there might be some kind of conclusion to the negotiations?

Ms Ure: I can't say when the conclusion will be. I can commit that there will be a meeting within the next two weeks.

Ms Martel: OK. May I just make this point? We've just received notice that one of the communities where the satellite is in—I understand, although I have not confirmed, that one of the physicians is closing his practice. There is already a waiting list for this particular CHC. The closing of a physician's office in an adjacent community is just going to aggravate that situation. So it really would be very helpful if we can move this along, because there are going to be a number of people who will be without a family physician all of a sudden as soon as this happens.

Ms Ure: Thank you for the additional information, and we can speed it up.

Ms Martel: You know that it is an area that is underserviced already, so we're working from that.

Ms Ure: We're aware of that, yes.

Ms Martel: Can I just go back to the more general issue, Minister? I hear you clearly say that you're supportive. The report that was done for your ministry certainly shows that CHCs were effective in dealing with all of the benefits from primary health care reform that you would want to realize and that I would want to realize. What I don't understand is why, if you say you're supportive and your predecessors have said they're supportive, there just has not been any kind of decision to expand the CHCs essentially through the whole piece of your government. There may have been two community health centres—

Interjection.

Ms Martel: —three that have received funding. That's far, far short of both the expansion that was underway under the Liberals and then under us. I really don't understand what the problem is here in terms of actually getting this process underway. If you believe they have a place in terms of primary care reform, when are we going to see some funding so that actually becomes a reality?

Hon Mr Clement: Certainly it's my intention to continue to support the roles that CHCs can play in our primary care system and certainly I'm working with them to make that a reality. So there really isn't much that we're disagreeing on here.

1550

Ms Martel: But can I be clear what you're working on? In the proposal they submitted to the ministry in the fall of 2000, the association clearly developed three different phases of construction. They had a number of communities that could be up and running in six months—that was by March 2001; that's how far back this goes—a number of communities that could be up and running by the fall of 2000 and March 2003, and then the third set of communities that could be up and running by the fall of—no, that's a continuation—by the fall of 2000

and March 2003. So they actually broke down for you those communities that could be up and running very early on and those that required additional work. Are you even working with that as a starting point to get this underway?

Hon Mr Clement: We were certainly apprised of all the various information and where each one is in the development of their plans. We see them as an integral part of what we call the family health networks and primary care in our province. They will have an appropriate and important place.

Ms Martel: Soon?

Hon Mr Clement: Well, you know, I'm not the Minister of Finance, but I would say that it's certainly part of our government's strategy to deal with this issue.

Ms Martel: I understand you're not the Minister of Finance, but I would say you're investing a whole lot of money on family health networks—$100 million and $150 million on technologies—and you're not much further ahead.

Hon Mr Clement: I disagree with that assessment.

Ms Martel: I'm not being critical of you. I'm not sure the OMA wants to be much further ahead—

Hon Mr Clement: I have to disagree with that.

Ms Martel: —but you could spend some money. For $115 million, you would have 65 new community health centres that would service over a million people with other health care providers—not just docs, but other health care providers—using their scope of practice to provide primary health care: treatment, prevention and promotion. I think there's a better way to spend some of that primary health care money that you're getting from the federal government.

Hon Mr Clement: We're all converging on the same point. Part of family health networks is to get the family docs off fee for service—the ones who are there now, the ones who are practising now. You cannot abandon that approach. It will not solve the problem to do just what you are suggesting. We need an integrated solution that involves the CHCs, and in many cases it might involve an expansion of CHCs in particular service areas. But that is not going to be the Holy Grail on this. You have to get the docs off fee for service.

Ms Martel: But the doctors who are part of the CHCs are on salary. That is part of it as well, right?

Hon Mr Clement: But they're not every doctor in every community.

Ms Martel: But if I might, Minister, the reality is that over the last number of years you have put all your eggs in the one basket. Essentially, all of your eggs on primary health care reform are in the family health network basket. You have not allocated a single new cent even in this estimate for an expansion of CHCs. That's the reality we're dealing with.

We would feel you were more committed, I guess is the best way to describe it, if there was actually some money attached and money put into the estimates to make this happen. But right now it seems that all the money you have for primary health care reform is tied up in family health networks.

Hon Mr Clement: OK.

Ms Martel: So I encourage you to please fund some more CHCs as soon as possible. I would be interested to get the information back about the one in my own riding.

I would like to deal with some issues around public health. I do have some questions about West Nile, despite your detailed description before, and I'll get there.

The first one has to do with a request for funding that has been made by the Association of Local Public Health Agencies. Last fall the association made a request to you for about $170,000. The estimates at that time showed an allocation of $150,000.

Hon Mr Clement: Do you mean million?

Ms Martel: It's $150,000.

Hon Mr Clement: For a particular—

Ms Martel: To fund the association itself, to fund ALPHA itself. They were told no and that there was no money at the time. When we did check the actuals, it appeared that no funding went out, even though it had been budgeted. Again this year I see in the estimates that a line item of $150,300 appears for the Association of Local Public Health Agencies.

Hon Mr Clement: That could be going to their conferences; I'm not sure.

Ms Martel: They also have their funding letter in to you as of August 19, 2000, to Dr D'Cunha, asking for that grant. I'm wondering if it is going to be provided to them this year.

Hon Mr Clement: Dr Kurji?

Dr Kurji: As you know, the Association of Local Public Health Agencies also receives funding from the local boards of health. In fact the ministry, through local boards of health, provides 50% of the cost sharing. So in some senses it would be incorrect for one to say that the ministry is not supporting them.

In terms of various years in the past, in 1996-97 we provided them with $250,000. Around the year 2000 they were charged with the responsibility of assisting local health units with Y2K, issues and again they were receiving a fair amount of funding there. Subsequent to that, as more and more of the costs have been picked up by local boards of health through the membership fees they charge the local boards of health, and the local boards of health receive funding from the ministry, we have reduced the amounts we have been sending to ALPHA.

At the moment we do have $150,000 budgeted in case there are services or projects that we want, in which case we have the ability to contract with ALPHA for the delivery of those services.

Ms Martel: It sounds to me like it's no. Are you telling us no?

Dr Kurji: We have the amounts budgeted. In the event that we do require specific services from ALPHA, we would flow those dollars for those specific services.

Hon Mr Clement: It's kind of a place-over, I guess.

Ms Martel: What specific services?

Dr Kurji: In the event there are certain things that need to be organized and we require external agencies to be able to deliver those—in the past we have looked to OPHA, which is the Ontario Public Health Association, and we have also looked to ALPHA with regard to the provision of those services. By and large we are trying to manage our finances in a prudent way, and if we don't get value for money we won't flow those dollars.

Ms Martel: I'm quite curious about this, because I was under the understanding that for a number of years now they had received a direct operating grant from the Ministry of Health. Is that incorrect? I'm not talking about what they receive at the local level; I mean from the Ministry of Health.

Hon Mr Clement: For ALPHA?

Ms Martel: Yes.

Dr Kurji: Again, for a number of years we have actually been providing them with dollars, and as I indicated, in the year 2000 a larger amount was provided to them because of the Y2K issues. Over the years their dues from local boards of health have gone up; in other words, their membership dues from local boards of health. In terms of the ministry's funding of local boards of health, we fund up to 50% of local board of health budgets. So in that sense we are already funding ALPHA.

Ms Martel: Can I ask this question: you say you get value for money. Last year in the estimates, and I'm looking at 2001-02, page 159, there was a line item of $150,300. Are you saying they didn't get this last year, even though it was budgeted in the estimates, because they didn't provide value for money or didn't provide you with some specific work on specific issues? Is that what you're saying?

Dr Kurji: What I would be saying—and I would have to check exactly what services they provided for us last year, but the monies would have been given to them for specific services provided to us. That is basically the way we do business with most of these external agencies. If there are specific things we require—for example, the OCCHA, which is an accreditation agency, does specific jobs for us that we may not be able to do within the branch or we may consider them to be the appropriate agency to do a better job—then those dollars are available for the provision of those services. So we have the ability to provide ALPHA with the dollars, should the services we wish to have be the ones they would provide.

Ms Martel: Can I be clear that this has nothing to do with their being vocal about issues like Walkerton. Tell me this didn't happen as a consequence. They have been receiving support from the ministry on an ongoing basis for quite some time now, as I gather; I could stand to be corrected. Suddenly last year, even though in the estimates it appears as a line item, they get a letter saying the ministry is unable to commit to providing the supporting grant to ALPHA at this time, period, point final—no other explanation than that. I'm given to understand, as I listen to you, that that might well happen again in relation to their August 19 request for funding, which again, curiously, actually appears as a placeholder in the budget. Can you confirm that this doesn't have anything to do with their being vocal in a way that might have been critical of the government around Walkerton or other public health issues?

1600

Dr Kurji: I can assure you that that is not the reason why any of these decisions have been taken. In fact, in public health we do encourage advocacy. That is one of the roles of public health practitioners. That would certainly not be a reason now. Without going into a lot of detail, sometimes if there are perceptions about non-delivery in certain areas, then perhaps we may be a little guarded with regard to proceeding in certain areas. But in this case, as I indicated, the money is there but the decisions haven't been made.

Ms Martel: And when will the decision be made, so they will know?

Dr Kurji: Should we require a service that requires ALPHA to be delivering it and if we feel that that is a prudent use of the dollars, then that decision would be made in a favourable way.

Ms Martel: But do you have no timeline for letting them know about this?

Dr Kurji: At the moment, we haven't identified any particular needs that cannot be addressed by other means.

Ms Martel: One question on West Nile: I'm given to understand that some public health units have come forward to say the ministry is insisting that the $9 million be spent this year. Is that correct: the $9 million that was allocated in August?

Hon Mr Clement: For this year's budget, that's right.

Ms Martel: They're quite concerned that this, given that adult mosquitoes are mostly dying at this point, is not going to allow them to do a great deal of good work with respect to mosquito control, and that they may have actually asked you to have that carried over to the next fiscal year so they can get a start early on in the spring with respect to some of these programs. Is that correct and is that something you are open to considering?

Hon Mr Clement: I haven't heard that specifically. Maybe Dr Kurji has heard that. But I can tell you that we will allocate whatever needs to be allocated to do what we can do. In that sense, we're talking about public health here, and we're not going to—

Ms Martel: But if it's not allocated early enough on, and the $9 million wasn't allocated till August, it's a little bit difficult for them to undertake a larvicide program or other things. What they're asking you, because they're not guaranteed that this money is going to come next year, is that some of that actually be held over until next year so they can do some of those things early on, when the mosquito season actually starts.

Dr Kurji: We certainly are cognizant of that particular need. There is a difference in the financial years. The ministry's financial year ends March 31 next year. The municipal financial year ends December 31. The monies have been identified in the ministry's financial year. So in effect, the right way of thinking about this

would be that the dollars would be available for the beginning of the municipal budget.

The Chair: Thank you, Doctor. We have to move on. I'll turn to Mr Miller and the government caucus.

Mr Miller: I have some questions to do with alternative funding arrangements for emergency rooms. I'd like to start off by thanking the minister and his staff for assisting with some challenges in my riding recently to do with coverage of an emergency room. I'll ask specifically about alternative funding arrangements. I know you're looking at alternative funding arrangements; I hope that's province-wide, not just for my riding. I also wonder whether there are elements of flexibility being incorporated into these alternative arrangements for emergency room physician coverage for items such as seasonal volatility in the numbers of people coming. Of course in Parry Sound-Muskoka we have huge increases in the number of people through the summer season. I wonder if that's being considered when you're looking at alternative funding arrangements.

Hon Mr Clement: Thank you for that. Of course we're aware of the seasonal aspect of some of the areas of Ontario, where you get those huge population spikes. It is something we're cognizant of when it comes to our general funding issues with respect to operational funding. But if I can have Dr McCutcheon deal with the alternative funding arrangements and where we are on that, perhaps that would be helpful.

Mr Miller: That would be.

Dr McCutcheon: The alternate payment arrangements for physicians cover a very wide perspective of physician care. You alluded to emergency room activity; that's just one segment of the alternate funding arrangements we have in place. The alternate funding arrangements for emergency rooms cover a full spectrum of care, from the very busy emergency departments to the ones that are, as you say, seasonally busy or ones that are remote in terms of distance and where emergency service must be provided and yet the volume of service is not enough to support on a fee-for-service basis the physicians involved.

This ER AFA program has been extremely successful and has been taken up by many emergency departments. There is built into it a flexibility that recognizes the volume of patients seen and the complexity of those cases as well. We are sensitive to the annual volume. Now, if there are some specific areas in which physicians have not been able to take up an ER AFA for whatever reason, we always go and seek out what the reason is and endeavour to make adjustments to ensure that we are, first of all, still consistent in the program. We don't want to have a whole lot of variation, because if we do, we won't have a program. We ensure we have consistency. And there are still some issues we are endeavouring to address, particularly in the north where the arrangements are still a little difficult. Sault Ste Marie is one of the areas in particular where we are looking at some additional enhancements to the program.

Mr Miller: Will the alternative funding arrangement also be looking at on-call remuneration and anaesthesia services as well?

Dr McCutcheon: There's the hospital on-call funding arrangement that was part of negotiations with the OMA at the last contract, and that has been fully subscribed. There are many physicians now receiving on-call funding for being on call, both within hospitals and on call from home for hospital care.

There are some additional issues with regard to anaesthetists in particular because of a relative shortage of anaesthetists. We're looking at arrangements there where an alternate funding plan is developed for anaesthesia. Examples we've already put in place would be some the minister alluded to earlier this morning, and they were in pediatrics, in both the north and the south, and other arrangements in some other institutions as well.

Mr Miller: What about attracting locum physicians?

Dr McCutcheon: Some of the alternate funding arrangements, particularly for emergency departments, have some locum arrangements built into them. But we've also got locum arrangements built in through different locum programs so that locum availability has been significantly enhanced. There are also some other items that we're working on to try to still further extend the locum program, but we're just in the development phase at the minute.

Mr Miller: With this new alternative funding arrangement, the hospitals in my area, a couple of them at least, end up using operating dollars to bid up the funds available for doctors, to try to retain doctors and attract doctors. Is that something that will eventually be illegal?

Dr McCutcheon: Certainly the directive the ministry has given is that funding for clinical activity should come out of the OHIP budget and that funding for physicians' clinical activity will come out of the OHIP budget. At OHIP, we're looking at different arrangements so there can be some equality across the system. The last thing we need to do, particularly in a shortage situation, is bring about things that increase dissatisfaction. If there's inequity in terms of remuneration, that's a dissatisfier that could cause people to move from one place to another.

Mr Miller: Certainly, and it must make it hard for the hospitals to balance their budgets as well, when they end up having to use up their operating dollars to bid up these prices.

Dr McCutcheon: It certainly does.

1610

Mr Miller: I have a question on the budget item on page 132 to do with district health councils. I see the actual for 2001-02 is $18,233,000 and the estimate for 2002-03 is $9.4 million. Is there some reason for that?

Dr McCutcheon: Gail?

Ms Ure: Yes. Part of their budget is directly from base allocation estimates. The remainder of their budget comes from those areas they provide supports to. They were very helpful in looking at issues with respect to long-term care and also mental health. So part of the

mental health budget and part of the long-term-care budget, both community and facilities, is attributed to the district health council, and you'd see that reflected in the actual expenditures in those sub-lines.

Mr Miller: So that was a one-year—

Ms Ure: No, that's a continuing one.

Hon Mr Clement: It's another one of these cases where different parts of the budget have different segments appropriated to a body; in this case, the district health councils.

Mr Miller: Also on the same page I see a large increase in funding for Cancer Care Ontario. It looks like the estimate for this year is $312 million, up from $281 million. Obviously the government is placing an emphasis on cancer care and treatment.

Hon Mr Clement: Yes. It's one of these unfortunate things where the need is there. Part of this, which I announced in terms of the $72-million extra funding overall in various aspects of cancer care, is increased slots for radiation therapy and chemotherapy. Part of it as well is the introduction of new medications that are coming on-line for the alleviation of cancer and the eradication of it in patients. All of that represents part of the budget.

In addition, of course, there's the capital side of the budget. As we proceed with building the new regional cancer centres—the one in Oshawa is going ahead; the one in Peel has reached the final stage of negotiation and I think we're moving ahead on that. Those are a different part of the budget.

Then there's the research part of the budget, which I suppose is more appropriately part of the enterprise, opportunity and innovation ministry but certainly will have a very positive impact on our ability to research further therapies when it comes to cancer.

I don't know whether the deputy or assistant deputy—

Mr Miller: So the research part that shows here, the $4.6 million—there's a lot more being spent on cancer research in Ontario through other ministries, is what you're saying.

Hon Mr Clement: That's my understanding. It was a budget commitment—

Mr Miller: I seem to recall it's something like $30 million—

Hon Mr Clement: Fifty million, I believe.

Mr Miller: Fifty million? Much more substantial.

Hon Mr Clement: That's right.

Mr Miller: I'll pass to Mr O'Toole.

Mr O'Toole: Minister, I really appreciate your persistence and diligence here today. I want to commend you on an open and—I find you that way all the time, and it's just good to see that as a public view, knowledgeable and accessible.

I had a question that was of a more personal nature, but it's been brought up in a brief way, with respect to the community mental health reports. I want to thank Jean Achmatowicz-MacLeod, who has worked at the Whitby site; I think they're in the process of filing their report. But that isn't exactly the question.

I'm really talking about the divestment of the mental health facilities. I know the Whitby mental health board has struggled. All the members from Durham have met on several occasions—it doesn't just serve Durham, of course. I think there are 20-some MPPs involved. The board is quite frustrated. It's my understanding that they've got the transitional plan, and that transitional plan is money. There are a lot more complicated issues around it than just the severances and all the other kinds of stuff, which really don't, in the longer term—when you move toward the public health kind of thing, the community hospital situation or whatever board arrangement it is. Could you perhaps give me some sort of indication of where the Whitby mental health facility is in its divestment? What do I tell the board that's either there or leaving?

Hon Mr Clement: I will refer it at one point, but let me just state that we're quite concerned about proceeding with the final divestments and movement into community mental health. We have had great success thus far in various communities in that regard. I believe that four of the six have been completed. Whitby is perhaps one of the two largest that are yet to go. We're now in the stage where we're getting all these reports and recommendations on community mental health implementation, which I'm quite hopeful will help us move the process along with respect to the Whitby situation. I understand the frustration in the community. I share that and, from my perspective, want to move ahead as quickly as possible.

Mr Stolte?

Mr David Stolte: Dave Stolte, director of the health reform implementation team. Just to give a status update on the divestment process, there are six divestments that have occurred to date. There are four remaining: Thunder Bay, North Bay, Whitby and Penetanguishene. We're continuing our divestment discussions with the receiving hospitals in order to accomplish as much as the upfront work as possible. We are having communications with community advisory boards and as recently as yesterday met with community advisory boards and have heard from them that they're anxious for the divestments to take place.

Mr O'Toole: I appreciate that. On a slightly different topic, I have had the opportunity to speak with board people from time to time and I'll convey that it's still moving forward somehow in the next year or so.

Hon Mr Clement: They've been very patient, and I recognize that. It's been a longer process than we all envisaged starting out, but I remain hopeful that with health reform implementation and the emphasis on community mental health that that represents, we can continue to make progress.

Mr O'Toole: It's a terrific resource and a great facility, but it has had its problems.

I'm going to move to a slightly different topic in the next couple of minutes, just to put on the record—you sort of asked me to look at a few things. One is the broader picture of technology in health care, specifically under the umbrella of smart systems for health. I sort of

see it as the future of health care. As I said earlier, a couple of the demonstrations I've witnessed give me every confidence. Is that something that's been well received by the actual doctors and the front-line people?

Distance medicine is a perfect example—we talked about that earlier—where I can see all the infrastructure and technology in a videoconferencing setting at the other end, where the specialists really don't have to be there. They could be displayed quite readily. Is that a disincentive for remote communities that may not be able to build the human infrastructure because the human infrastructure will reside where the technology resides? They can do the diagnostics on-line. It's just incredible what they can do.

Hon Mr Clement: I think it's actually quite the opposite. My experience has been that in rural, remote and northern communities, for instance, the accessibility to network health information and the distribution of some of that health information, of course within a privacy framework, is actually an incentive to continue to remain in your profession in your chosen community.

There are lots of advantages in northern and rural Ontario—a standard of living and quality of life—that sometimes were not enough to keep those medical professionals in place. With the use of the IT you have seen, they can feel part and parcel of their profession. They can feel they are getting continually educated and updated. They can feel that with a click or just a computer screen away, their colleagues, people with specialized skills that were unattainable to them before, are now within reach. It provides a comfort level that allows our medical professionals to stay on top.

Mr O'Toole: I have been privy to watching collaborative conferencing on-line in real time and, as you say, consulting with the very latest specialists. In fact, it would be called post-doctoral education because it's real time, real application. It's part of that I'm talking about, because the public, including myself and members of caucus, maybe aren't aware of those innovative strategies that you have really pioneered and brought forward.

I think we need to communicate and set up a communication plan to keep the public up to speed and bring all of us along to make sure that we have a comfort level with emerging, innovative strategies that are part of the solution; not just more docs, in the traditional mode, but integrating the technology and the human resource to retrain and improve health outcomes and diagnostic tools. This is one of them that I see. I wouldn't presume to imply that I know very much about it except that I have had the privilege, thanks to you, to see several applications at the site, to work with your staff, and to put on the record that I am impressed with what that means. But I believe that the innovation is clearly there. There are some results I can see, that sometimes the culture is lagging a bit behind, taking that next bold step.

The Chair: Two minutes.

Hon Mr Clement: May I just comment on that? You're absolutely right. There is starting to be a lot of attention paid to this. Time Canada, either this week or next week, has a whole supplement on Canadian technological developments in medicine, where a lot of our hospitals in Ontario and other health facilities and practitioners are being showcased. That's all good news. We could probably have a whole session of this or some other standing committee where we talk about some of these issues: reducing medical error with an electronic medical record; having bar codes on medications so that if the bar code doesn't match the bar code of the patient in the hospital you don't have access to the medication. So all of a sudden you've got a way to double-check to make sure that that kind of medical error doesn't occur. There are all sorts of patient safety issues that will be helped with technological advances. It really is now occurring at quite a pace.

Mr O'Toole: Just on one final issue, the health privacy issue which you alluded to earlier: the health privacy issue is of a complicated nature in the fact of how far down do the rules apply. I've heard the federal Privacy Commissioner speak and I'm somewhat troubled sometimes when I hear his prescriptive manner, but at the same time I'm sure it came up at the first ministers' conference that there needs to be a national plan, because whether it's communicable diseases or other things, we need to be sharing patient records and other kinds of medical records. Are you confident that the health privacy forum that's going on—there's a debate provincially, of course. Is there going to be a national kind of standard or protocols?

Hon Mr Clement: There certainly is some evidence that the federal government wishes to play some form of role in this. Some of it might actually be positive in the sense that one of the things they've got is this Canada Health Infoway network; $500 million allocated to this and we have yet to see a penny, really, come out of that. But if that actually gets going that will be very helpful.

The Chair: Minister, your time is up. I also would like to offer you a five-minute break. It's been a long day. With the indulgence of everyone else, before we start the next round, maybe five minutes to freshen up a little bit and resume. Is that all right?

The committee recessed from 1624 to 1633.

The Chair: Minister, welcome back. We are now ready to start with the official opposition.

Mrs Pupatello: I'd like to ask the minister some questions about hospital funding. Specifically on page 71 of the estimates, you've indicated you're showing an 11% change in the operating of hospitals. I'd like to know how you arrived at that particular amount to be increased to the operating of the hospitals.

Hon Mr Clement: It's done on a year-to-year basis is the quick answer, and perhaps somebody can elaborate on that? John McKinley, acting executive director, health care programs division. Welcome.

Mr John McKinley: Thank you. The very simple response to that is that there were two components of that increase on the year-over-year. One of it is the announcement that was made in the previous year—the $300 million that was made last year was annualized, plus the

$645 million that was announced this year. So those two components make up the—

Mrs Pupatello: Did you just pick that out of the air?

Hon Mr Clement: No, of course not.

Mrs Pupatello: Did you say, "I think we'll throw in 300 more," and then you said, "Let's throw in another six"? Where did the number come from? How do you arrive at the number?

Hon Mr Clement: The number is a result of our careful review of the operating plans of each hospital, which are pored over by staff to see what their trends are.

As you may know, there is a new hospital funding formula, which is in the process of being implemented bit by bit, that takes into account acuity levels, population growth and other factors that help us work out the appropriate funding. I think that's a synopsis of how we do that.

Mrs Pupatello: So it's a meticulous, line-by-line review of each hospital's budget requests?

Mr McKinley: No. It doesn't work totally from budget requests. Also, there are a series of programs identified that are provincial programs that we work with, groups like the Cardiac Care Network of Ontario, to establish what targets of services are going to be, and they are funded from a provincial perspective as opposed to just on what the hospitals submit to us.

Mrs Pupatello: It's just that there is, as I said earlier in response to one of the government MPP's questioning around hospital money—I had suggested that 70% of the hospitals are actually in deficit. So it's going to be hard to hold them to account and not give them a CT because they're in a deficit while 70% of the hospitals are in deficit. I need to correct the record because in fact 75% are in deficit, not 70%.

I'm wondering how you determine that there are so many that are underfunded. The amount you have allocated really doesn't resolve the debt situation. So money you're giving them for operating will in fact be used to give money to the bank, essentially, for finance charges because they're having to finance their own debt.

Hon Mr Clement: Could I just put this in perspective to help you understand what the situation is? There is an accumulated sort of system-wide number of about $300 million from last year. You're correct about that. Most of the deficits of most of the hospitals that are in deficit are fairly modest. There are some exceptions to that—four to six exceptions to that, depending upon how broad you want to cast the net—and some of those are hospitals where there are operational reviews going on, where clearly something is not working right either in management or in the funding formula, or something has gone wrong where the deficit has ballooned.

So if you look at the actual funds involved in those cases—that is over half, as I understand it, of that $300-million number—those are part of a separate review and a separate collaboration with the hospitals to try to fix something that obviously has gone wrong along the way.

I wanted to put it in that perspective for you because I wouldn't want to leave you with the impression that each hospital faces an equal amount of deficit. That is not the case. Indeed, the alarming numbers are in a relatively small number of hospitals.

Mrs Pupatello: Yes, and I guess what we're saying is that based on Ontario Hospital Association reports, whose job it is to do this review as well of all their hospitals, etc, they're estimating half a billion dollars—that was 2002-03 net operating underfunding—and a working capital shortfall of over $1 billion. So we're talking about significant underfunding, and I wondered how you decided that you would arbitrarily, or by virtue of—and you've answered the question—a meticulous review of their hospital budgets—

Hon Mr Clement: Certainly, their operational requests are reviewed that way and, as I was reminded, we also have priority programs. I think we should put on the record that the Ontario Hospital Association praised the Ernie Eves government for their hospital-funding announcement of this year, a 7.7% increase from last year. While there are issues that have to be resolved and can be resolved through our multi-year funding initiative, I should state for the record that there was a recognition by the hospital sector of the immense increase in funding that was able to be delivered this year.

Mrs Pupatello: I'll tell you, Minister, the Ontario Association of Community Care Access Centres also praised the legislation that eliminated them, just to put those comments in perspective in the politics in Ontario today.

Let me tell you that in fact—

Hon Mr Clement: More evidence that we're on the right track, I guess.

Mrs Pupatello: I wish you and I both had more time, actually. There is information coming to us from the Ontario Hospital Association that there is not a minimum 3% increase in the total operating funding for hospitals across the board, which indicates that the monies you've allocated, in fact some are getting more, some are getting less, and whether it's by population growth in particular areas, whatever it is, there are many hospitals that are not getting even 3% of an increase to accommodate local economic pressures. So we have some communities who won't see even 3% of an increase.

Hon Mr Clement: It's curious you should use that number, because you know that everyone is getting at least 2%.

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Mrs Pupatello: Also, just based on your answer previously, where you said there's a meticulous review, line by line, of hospital budgets before you come up with the $645 million, I think you said, and $300 million from last year, why has $98 million, then, not been allocated to date?

Hon Mr Clement: There is a good answer for that, and we are just about to provide it. Go ahead, John.

Mr McKinley: There are a number of programs that do not have final estimates of volume or service requirements that are identified at the beginning of the fiscal

year and so that we can plan exactly which organization will be doing those particular volumes.

For example, we have a number of HSRC directions that we are implementing across the province that are expanding the services in rehab and complex continuing care. We are in the process of negotiating the end budgets for those particular organizations right now. When we complete those negotiations, we can then allocate the funding. We've allocated it by a global amount, and there is still $98 million to be cash-flowed. But it depends on the results of the negotiations on the services that the individual hospitals are going to provide.

Mrs Pupatello: There's been an alarming trend with this current government that a lot of the money is allocated in a budget and actually never goes out the door. And in the case of the health ministry, where it comes to capital costs borne by these hospitals—and they're incurring major debt as a result of the capital changes of local hospitals, restructuring etc, frankly many cases being foisted on them by government policy, and then the debt being incurred by the hospital and then an incredible delay in the money actually leaving the ministry and arriving at the local community. That debt charge is being borne by the hospitals' operating. So it's frustrating to watch many hospitals using operating dollars that should be going to patient care going to the big banks here at Bay Street and King Street. That's tough to watch.

Let me move on to a couple of questions to table for information from the ministry. I'd like to have the new ambulance response time standards that were being developed, and if they are available to us, we'd like to have them tabled. Also, how many communities are meeting this new standard in ambulance response times? There was some of that information available, outdated; we'd like to have the new standards that the government was bringing in.

Hon Mr Clement: Just so I understand, before we actually funded for improved response times, you want to know how many communities are not meeting the response times before we've spent all the money to improve response times?

Mrs Pupatello: No, we're asking you what the new response time standards are, and I'd like to know which communities are meeting them now.

Hon Mr Clement: Right, before we've actually flowed the funds so they can meet the response times?

Mrs Pupatello: The history has been that you downloaded the ambulance responsibility to another level of government, and then you mandated a standard that you didn't even meet when you were responsible for it. So—

Hon Mr Clement: I'm sure we can provide that information, with that caveat in it.

Mrs Pupatello: Let's be fair to all concerned. I would like that information tabled, Minister.

I'd also like to understand what the status of privacy legislation is right now. Much of the advancement of primary care reform, which seems to be your priority, that's not doing well at all—IT is such a significant part of it. Where is the privacy legislation at the moment?

Hon Mr Clement: As you probably know, Minister Hudak is the lead minister for the overarching privacy legislation. There is a significant health care component of that. Certainly it is under consideration by the government as to the timing of the introduction of that bill. So you might want to ask your House leader what he may know.

Mrs Pupatello: Is there a significant part of this that deals with health-related issues?

Hon Mr Clement: I believe I just said that, yes.

Mrs Pupatello: Is there some department individual who's responsible for all of that?

Hon Mr Clement: Yes, there is.

Mrs Pupatello: And who would that be?

Hon Mr Clement: Phil Jackson. Is Phil Jackson here? Phil Jackson is the director of the health information privacy and sciences branch of the integrated policy and planning division of the Ministry of Health and Long-Term Care. Do you have any questions for him in particular?

Mrs Pupatello: Yes, and I guess we can ask him, then. I'm sure he's worked on this most of his career, I think, the same piece of legislation; it's been around about 20 years, I think, Minister.

I'd like you to explain the change in the children's treatment centres budget line on page 71.

Hon Mr Clement: I'm sorry. Were you going to ask some health privacy questions?

Mrs Pupatello: No, I'll take that up with him at another time. I just needed to know who. I didn't know if you had any involvement at all in privacy legislation now that it's in another ministry.

Hon Mr Clement: Of course we do, yes.

Mrs Pupatello: The children's treatment centres: it appears as though there's a $3-million loss to that area in terms of funding. Maybe the minister could explain why. That's itemized on—

Hon Mr Clement: And that's on page 71?

Mrs Pupatello: Children's treatment centres.

Hon Mr Clement: Is it page 71?

Mrs Pupatello: Yes. I think most of the agencies out there are telling us that the waiting list for treatment for children is—

Hon Mr Clement: As you know, if I can await the presence of the individual who might have a more elaborate answer and indicate that our government is proud of our massive infusion of at least $20 million into the CTC sector, which was praised by the sector as being necessary and appreciated. But now that I've said that little free advertisement, John McKinley is here, the acting executive director.

Mr McKinley: The CTC's line was that there was going to be the funding available for the programs that were announced last year. The difficulty we had was in intepreting the timing of some of these things, so the budget may not have been adequate at this time. But we have come up with a plan in-year to make sure we

manage the pressures on the CTCs at this point, fully committing the government's commitment to the $20-million expansion.

Mrs Pupatello: Will any of the children's treatment centres be reduced in their budgets at all?

Mr McKinley: No.

Mrs Pupatello: OK. I'd like to ask about radiologists in Ontario. We have a significant shortage of radiologists and it's a significant problem. They listened to you announce that you're going to send out an RFP for 20 more private clinics, requiring radiologists, I'm assuming, to run them.

Hon Mr Clement: Independent health facilities: are you referring to those?

Mrs Pupatello: I'm referring to the RFP you haven't released yet for the private clinics.

Hon Mr Clement: For the independent health facilities, right; the independent health facilities that were passed under Elinor Caplan.

Mrs McLeod: And changed by the Tories.

Mrs Pupatello: Are you going to need radiologists for these facilities?

Hon Mr Clement: Absolutely, we will.

Mrs Pupatello: Where will they come from?

Hon Mr Clement: I think we've got some good news coming down the pipe on that front in the next little while.

Mrs Pupatello: So are you aware that there's a current shortage in all the hospitals across Ontario that require radiologists?

Hon Mr Clement: I'm aware of the situation, absolutely.

Mrs Pupatello: And will you be prepared to see that those facilities that already need radiologists will get them first before you use any of the new radiologists you seem to be finding for these private endeavours?

Hon Mr Clement: I think you'll be very positively impressed with an announcement that will be occurring very soon.

Mrs Pupatello: The number that the Ontario Association of Radiologists put forward was that we were short 150. Have you found 150 radiologists from outside Ontario?

Hon Mr Clement: As I say, I think you'll be very happy in the near future with my response to that.

Mrs Pupatello: Well, Minister, you can understand why we'd be so frustrated. First of all, if they come from outside Ontario, you can't seem to get foreign-trained physicians to practise in Ontario. Even if you give them a six-month fast-track assessment, that means they're not going to be available this year. Is your RFP coming this year? You announced it this past spring. So unless you've found a way—one of your predecessor ministers of health said they were going to scour the earth far and wide to look for physicians. In that context, it was oncologists that we were short of. What that minister failed to understand was that even if she found them far and wide, your own policies don't let them practise in Ontario. So we're back to the issue of foreign-trained physicians.

Now please, this is a very serious issue. The radiologists have told us that we're short about 150. We know that those we speak to personally are working hours that really are fairly inhumane. The working conditions for the staff that work with radiologists are fairly inhumane. I'm presuming that the private clinics you're putting out an RFP for are going to require these same kinds of personnel. What has happened already when you did this model in the private cancer clinic—the people working there work a full-time day in the hospital. Then they get employed part-time and they go to work at nighttime, and they go to work in the private clinic. So you are either driving the same personnel into the ground, because you're grinding them to work and just churn out more hours—I'd like to see if there's any data available through the private cancer clinic that has anything to do with the quality of the outcome for those patients, by the way. In any event—

Hon Mr Clement: Oh, I would watch what you're saying, Mrs Pupatello.

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Mrs Pupatello: But I do think it's important for you to tell us. You told us this past spring you're putting out an RFP for private clinics that are going to require radiologists. We have hospitals across Ontario that are begging for the CTs, that have already fundraised in communities to have them, and you won't allow them. And today you—

Hon Mr Clement: That's not true.

Mrs Pupatello: You're not allowing two in Parry Sound.

Hon Mr Clement: That's not true. I did not say—

Mrs Pupatello: You're not allowing one in Lake of the whatever in the Whitby region.

Hon Mr Clement: No, that's not true.

Mrs Pupatello: The point is, you're going to need radiologists to run these facilities. If you've got some plan to bring 150 in to resolve the current shortage—we already are short. Where are they going to come from, then, to be able to operate in these new facilities?

Hon Mr Clement: It certainly is an important question, which I am aware of.

Mrs Pupatello: You're just refusing to answer the question, then.

Hon Mr Clement: No. I'm saying the answer to the question is that we do have a plan and we certainly will be making that available soon.

Mrs Pupatello: Do you have the same kind of plan, this kind of divine intervention, to provide additional staffing requirements to the technologists who are going to work with the radiologists? Are you finding them as well?

Hon Mr Clement: It's nice to have divine intervention, but I do try to plan in the absence of that.

Mrs Pupatello: Minister, I think you need to be serious about this.

Hon Mr Clement: I'm absolutely serious about this.

Mrs Pupatello: Where are the radiologists going to come from for the RFP process that you announced this spring? You said this spring that a private company can come in and bid.

Hon Mr Clement: An independent health facility is quite capable, either in partnership with a public facility or on its own, of delivering excellent quality care to the standards that we expect, and delivering accessible care, because the public in Ontario demands greater accessibility to diagnostic services.

Mrs Pupatello: I think it's fair to say that the public also demands to know that the Minister of Health looks past the end of his nose before he introduces some new way of doing things; that you recognize as the Minister of Health that we lack radiologists. You want to go headlong into some new area. Where will the people come from?

Hon Mr Clement: It's not a new area, Mrs Pupatello.

Mrs Pupatello: Where are all of the specialists going to come from in order to operate the new facility?

Hon Mr Clement: Independent health facilities have been operating in our province since Elinor Caplan passed the legislation in 1989.

Mrs Pupatello: Minister, I think it's reasonable that you be able to sit in front of the estimates committee and explain yourself and not say, "We think you might like the answer that may come in the next six months." Estimates committee is to put you on account for the things you have announced and a budget you are producing.

Hon Mr Clement: I am aware of the function of the estimates committee.

Mrs Pupatello: Well, we expect an answer.

Hon Mr Clement: I gave you an answer, Mrs Pupatello.

Mrs Pupatello: I don't think that telling me that at sometime down the road you might have an answer is acceptable in any way.

Hon Mr Clement: I don't expect you to agree with every answer I give, but that's the answer I gave.

The Chair: Mrs Pupatello, your time is up. It is now over to the third party.

Ms Martel: Minister, I just have this 20-minute round that I do and then I have to pick up my kids. I know you'll be sorry to know that I can't do another 10 minutes, but someone else will pick that up for me, I'm sure.

I wanted to deal with the public health budget again, if I might. I had two other questions about the estimates that appear on page 118. First, on page 118, under Funding Increases, Safe Water, $1.3 million: can I ask what that is an allocation for?

Hon Mr Clement: If I can rely upon Dr Kurji to give some details on that.

Dr Kurji: In February 2002, Ontario regulation 505/01, Drinking Water Protection – Smaller Water Works, came into effect. This regulation is intended to protect vulnerable populations, particularly children, the elderly and those who may be immuno-compromised or institutionalized. Regulation 505/01 primarily applies to government-funded facilities, social services facilities and educational facilities. There are small communal drinking water systems on private but not municipal water systems.

The Ministry of Health and Long-Term Care is designated as the interested authority for 69 such facilities. The ministry is responsible for providing adequate funding to bring a drinking water system into compliance with the proposed regulation to ensure that each one of these 69 facilities continues to meet the prescribed regulated requirements as they relate to testing, sampling and reporting on drinking water quality.

The funding will actually support two FTEs for oversight of the Ministry of Health designated facilities. It will also fund for the increased volume of lab tests resulting from the new regulation and funding for local health units to hire staff in response to the introduction of regulation 505.

Ms Martel: OK. And that's going to be 100% funded; it's not going to be clawed back at any point; that's what they're going to get as an allocation? You will have to do some work, but also the public health units as well. It's not going to be clawed back. Wasn't this part of the line item last year? You wrote to some of the health units and asked them to give some of the money back for safe water. Is this the same line item that we're talking about?

Hon Mr Clement: This is an initiative that is ongoing right now, so there's no reason to claw it back.

Ms Martel: All right. The same, two down, with meningococcal immunization vaccine. It would have to be bigger.

Hon Mr Clement: I know.

Ms Martel: It would have to be a lot bigger to do what I want it to do, but I'll get to that too. I'm just curious about what that is funding actually.

Hon Mr Clement: As you know, based on the recommendation of a local medical officer of health, if there is a need to vaccinate an area that has been touched by meningitis, we do have a line item for that, and I'm presuming that's what this line is about.

Dr Kurji: That's correct, Minister. In fact, as the minister has articulated, what this addresses is actually two things. One is outbreak control, which is one of the older NACI recommendations. So the vaccine is available for control of outbreaks. In addition to that, we have implemented one of the other NACI recommendations, which is really to provide immunization to close contacts and household contacts.

Ms Martel: People who have contracted meningitis already?

Dr Kurji: That is right.

Ms Martel: Just while we're on meningitis, Minister, this is a question for you. I have been asking you for a fair amount of time now about a province-wide program.

Hon Mr Clement: You've been quite relentless, actually.

Ms Martel: I saw the correspondence that indicated you were approaching the feds on this and you really wanted to see what the federal government would do

before you moved forward. I've made the argument, which you know, that two other provinces have gone ahead on their own and done something about that. Two points: I guess I'd have a question about whether you have any other news from the federal level that they are prepared to participate. I also want to raise with you the potential of a program that would be ramped up or scaled down, depending on how you look at it, that I think is well achievable at least for the highest risk population.

Hon Mr Clement: It continues to be a topic of conversation at the highest level with the federal government, with my counterpart Anne McLellan, and that continues to be the case given the NACI recommendations or findings. Certainly in this country we have had experience with national campaigns. The polio campaign was a national campaign. Paul Martin Sr was the one who initiated the polio campaign. When we have a national issue of public health, which is what NACI is supposed to concern itself with, it stands to reason that the federal government would come to the table if they identify a public health matter that they wish to be dealt with. We have yet to see that, unfortunately.

Ms Martel: I understand that, but the province of Ontario made a determination that the flu shot campaign was very important, and that is not a national program. You're not receiving any federal funding to do that, and you're spending $44 million. I think meningitis vaccination is a public health issue. Are you prepared under any circumstance to look at going at it alone, as you did with the flu shot campaign?

Hon Mr Clement: I think the short answer is yes. If there is a conclusion clinically drawn by public health officials that I actually feel I'm required to listen to, that the only way to deal with a severe situation is through a province-wide vaccination program, then I think I would be delinquent in my duty if I did not take that advice.

Ms Martel: I'm not referring to a severe situation, but you are getting resolutions from a number of public health units now, I think from a May meeting that was held, urging you to look at vaccination not only for meningitis C but for at least three other programs, so that that vaccination would become part of the routine vaccination for infants. This is not just I talking about this now. I know that resolution was passed at ALPHA, and I know that a number of individual health units, like my own, have written to you to encourage you to do the same thing. So there is a movement of public health units that feel this is a public health issue and that you should consider an extensive vaccination program. They're citing not only meningitis; they're citing at least three others. I've been talking to you very specifically about meningitis. Is that a group of folks you're prepared to respond to?

Hon Mr Clement: Again, it's an issue that I'm apprised of. There are differing clinical points of view of need and efficacy, which I also have to take into account. In terms of the NACI recommendations, if the national government feels this is a priority, then they know what to do about it. I don't know, Dr Kurji, if you've got any other comments on this issue.

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Dr Kurji: Basically, with respect to the meningococcal immunization program, there are certainly provinces like Alberta and Quebec that have introduced the immunization program. I think Alberta certainly has introduced it. But we have to really examine the background. Alberta was experiencing a lot of outbreaks in the Calgary-Edmonton corridor. So they started out implementing the previous NACI recommendation regarding outbreak control. In so doing, they immunized about 50% of their population. In Quebec, Quebec City and Montreal were really experiencing a lot of outbreaks. So again you had another province where about 50% of the population got immunized as a result of outbreak control measures. With the ongoing outbreak activity, it made more sense from a cost-benefit standpoint to proceed and immunize the rest of the population.

With respect to other provinces, Ontario being included within that, the levels of activity, certainly in Ontario, have been lower than those in Quebec and Alberta. What we have predominantly been arguing at the federal table, through the minister, is that just as there is inequity in the distribution of vaccinations across the country—for example, Ontario provides universal immunization for the flu where other provinces don't, and other provinces may provide other vaccines that Ontario may not. With the desire that this be done in an equitable way across Canada, the minister has engaged in conversations with his federal colleagues. NACI is actually a national committee which reports to Health Canada and to the federal government in that regard.

Ms Martel: I know that. Alberta's program will now become routine. Yes, there was an outbreak and they dealt with that and immunized a large percentage of the population. But their program is now going to be a routine program for infants during regular immunizations, so this will be an ongoing program. Ontario could even look at that. That's obviously not what I've been asking for, but even if they did, that would be a cost that would be even less than your flu shot campaign, if you wanted to look at newborns, for example, or up to the first year, or even if you included first year and down. There are a number of ways that you could approach this if you wanted to decide this was an important public health issue for you as well. You might wait for the feds, and you might wait a long time. I'm suggesting that infants or young adults shouldn't have to die in this province from a disease that we can control.

Hon Mr Clement: Based on my experience in the last year or so, it's not confined just to that group. It's a case, and a case can be a high school student or a young person in elementary school. It certainly is not confined to newborns. Each case seems to be different. Of course, we're dealing with a disease that sometimes is more effective than others in terms of our population. That's the affliction we're facing. There might have been cases

of newborns in the last year—I don't know—but my recollection is that it wasn't newborns.

Dr Kurji: The minister is quite right with regard to the different age distributions. One tends to get it in the under-five age group and also in the young adolescent age group.

With respect to Alberta's having immunized 50% of its population because they had to do so to control outbreaks, it then becomes cheaper to proceed and immunize everybody else. So the cost-benefit ratio is somewhat different. When you look at other provinces, they have to immunize the whole of their population, and hence the cost-benefit issue is somewhat different. I guess that was the point that was being made earlier.

Ms Martel: I understand that. It would be good to start somewhere. Even in Alberta they will now have a regular program for infants every year. Michael Maxwell was 17. That wouldn't have helped Michael Maxwell. Having said that, there is a vaccine, it has been recommended, it is safe and right now it is cost-prohibitive for many parents, if they even know about it, because regrettably there aren't large public education campaigns about the need to get this vaccine. I just think it would be responsible of us to look at a program, even on the scale of Quebec, even looking at Alberta, even looking at infants, that would at least get us started.

Hon Mr Clement: OK, I hear you.

Ms Martel: Two other questions. This was with respect to tobacco tax, because in your opening remarks, Minister, today you talked about a focus by the ministry on wellness and health promotion. You talked very specifically about the impact of smoking, that it's the leading preventable cause of premature death, disease and disability. If I understand correctly from the budget announcement, Ontario will take in about $1.3 billion by adding a $5 tax on a carton.

Hon Mr Clement: I don't think it's that high, actually. No, it would not be that high.

Ms Martel: I thought it was.

Hon Mr Clement: I think it would be closer to $342 million or something to that effect. That's just off the top of my head.

Ms Martel: I'm sorry, I thought it was much higher. My apologies.

Hon Mr Clement: The number 342 seems to be stuck in my mind, so it must be around that, but we'll double-check it for you.

Ms Martel: What I'm interested in is whether any of that is going to be dedicated to smoking cessation programs or dedicated to dealing with the excellent report that was done by the expert panel for your colleague Ms Witmer on getting serious about tobacco control. You have this money coming in. You've said prevention is a priority. You've identified tobacco. The only recommendation that appears to have been acted upon is the one to actually apply an increased tax, which you've just done, but there are 28 others that would deal with a broad range of initiatives the government could undertake. Is any of that money going to be dedicated?

Hon Mr Clement: Certainly now that my youth tobacco team has reported, I have directed a review of our entire tobacco control strategy, both from a regulatory point of view as well as from advertising, education and those kinds of initiatives. There's no question that a tobacco tax has a disproportionate and therefore positive impact in the incidence of youth taking up smoking. There's no question that the evidence is in on that. The elasticity of demand is much higher among young people than among adults who take up smoking. So already I believe we have had an impact on juvenile smoking by increasing the tobacco tax, is what I'm trying to say.

There's no question that we're dealing with an industry which is an insidious, horrible industry—I'm talking about big tobacco now—that has been proven in many jurisdictions to have consciously sought to increase profits by preying upon non-smoking adolescents, which is as unconscionable an activity as one can imagine. They are an industry that always tries to find the way to subvert well-meaning legislation, advertising and other forms of regulatory control. That's whom we're dealing with.

In my mind, we are learning. Just at the health ministers' meeting we learned of other approaches that provinces have taken just this year which I would like our province to consider in due course. But you have my commitment that I am not about to let them get off with their types of advertising, the types of promotion they do which have been shown in other jurisdictions to be consciously directed at the advance of youth smoking. It's just not acceptable in our society, and we'll have to deal with it.

Ms Martel: Two questions: when will we know how much of that tobacco tax will be diverted back to programming on the broadest level, and will you also be making a specific announcement about how much of that money might go to actually implementing some of these recommendations?

Hon Mr Clement: As I say, I've directed the review to be quite quick from our ministry's point of view. I believe that a lot of facts and options are on the table, so I undertake to get back to you at the earliest available opportunity. This is something that the Ministry of Health will have to have some dialogue on with the caucus and with other members of government, but I'm quite hopeful we can make some progress.

1710

Ms Martel: My final question has to do with the patients' charter. Page 52 shows an allocation of $3 million for a patients' charter. I'd be interested to know what that funds.

Hon Mr Clement: Well, the patients' charter of rights and responsibilities is a government commitment to ensure that we move forward with a plan to increase accountability in the delivery of health care, to make it more patient-centred and more responsive and responsible. It's an ongoing initiative. It is connected to other projects and plans. With that, I will leave it to George Zegarac to provide more detail.

Mr Zegarac: As the minister indicated, we are looking at consultations around responsibilities, but also on rights. We have had discussions with a number of focus groups to look at what their expectations would be, what their issues are around access to rights, how they would like to see it implemented. We've had consultations with stakeholders. We are also looking at a support network, the possibilities around a 1-800 line or other types of support networks to ensure that the public knows what their rights are and that there is some accountability in the system. So it's basically there to help support and design the new charter.

Ms Martel: Is that money that has already been spent?

Mr Zegarac: Some of it's being spent right now as we're doing the consultations and other money will be spent in the future.

Ms Martel: Outside of the consultation you had this summer with this four-page document with a number of people behind closed doors, what else has been done on this dossier?

Mr Zegarac: In terms of—

Ms Martel: Of developing the charter, that would bring you to $3 million.

Mr Zegarac: When the announcement comes out with the details on what the government's response on this is, it will have a support network of activities to support not only the articulation of the charter and the responsibilities and the rights, but also to support the public getting access to that information, and a follow up. So there will be a number of initiatives and activities that have yet to be announced from the government that will also be implemented through that.

Ms Martel: Just as I close, could you provide me a little more detail about how much has come out of the $3 million so far and for what?

Mr Zegarac: Yes, we can certainly provide what's been spent to date. That's not an issue.

Ms Martel: OK, thanks.

The Chair: We now turn to the government caucus and to Mr Mazzilli.

Mr Mazzilli: Earlier we were talking about enhanced ambulance funding and that you may now have some numbers. If it is the upper tier for the county of Middlesex, do you have the numbers that that community would be enhanced by?

Hon Mr Clement: In Middlesex? I know that we are just finalizing some of the discussions with the municipal governments on that front. We do have a breakdown on our front.

Mr Mazzilli: It's administered by the upper tier, so that would be the county of Middlesex.

Hon Mr Clement: I believe in Middlesex the number is $745,000.

Mr Mazzilli: It's $745,000?

Hon Mr Clement: Yes.

Mr Mazzilli: And that would be, obviously, the province of Ontario portion matched by the county of Middlesex, so it's an enhancement of some $1.5 million in ambulance service.

Hon Mr Clement: That's my understanding. Of course, I can't speak for the municipality, but we have to have some final—

Mr Mazzilli: Certainly, and I know the county had put aside some money as of last year to enhance services but was waiting for our contribution, so I know they'll be very excited in London. I'll be happy to pass on that information.

Hon Mr Clement: Please do. Keep those cards and letters coming.

Mr Miller: I'd just like to ask about the Healthy Babies, Healthy Children expenditures on page 107. I see that the actual amount spent in 2001-02 was $61 million. That was up substantially from the estimate, and again this year it looks like a fairly substantial increase to $67 million for the estimate for this year. Can you talk a bit about that program and why the actual was $10 million more than the estimate?

Hon Mr Clement: Sure. As you know, we try to integrate our services for children amongst different ministries so that the left hand knows what the right hand is doing. In that vein, if I can defer to Peter Rzadki, who is the assistant deputy minister in charge of integrated services for children, I'd be much obliged.

Mr Peter Rzadki: Sure. The straightforward answer to the question is that the 2001-02 estimates were restated to reflect an internal reallocation of the federal ECD funding to other ministry transfer lines or payments that relate to programs and services that families and children in the Health Babies, Healthy Children program are referred to, if that's necessary. However, the 2001-02 interim actual figure, the one showing $67 million, was not adjusted to reflect that. So the $10 million is not in fact an increase in Healthy Babies, Healthy Children spending; it is an increase in other programs that parents and children in that program are referred to for services they require.

Mr Miller: Can you talk about the Healthy Babies, Healthy Children program?

Mr Rzadki: Absolutely, we can. As you may know, the program was launched in 1997 by the government to respond to the need to have a more consistent screening and assessment system out there for newborn infants and their families. The budget in 1997 was $10 million, and it quickly grew to reflect a number of enhancements that were announced by the government, including the 48-hour guarantee, which guarantees families a call or visit by a public health nurse within 48 hours of the birth of their children.

Recently, the program was also enhanced—I guess last year—with federal ECD money to take a look at improving the way our family physicians, nurses and other practitioners undertake an 18-month assessment of children's needs for those families who are in the program and are determined to need some ongoing monitoring. We are developing a more universal tool so that kind of assessment and screening at that age can be

undertaken. Additional funding has been provided through Healthy Babies, Healthy Children to train the primary care providers to understand the tool and use it.

Mr Miller: On page 117, the outbreaks of diseases line, I see it was estimated at $58 million, and the actual for 2001-02 was $65 million and there's an increase in the estimate even from that $65 million. Are we having more outbreaks of diseases? Can I have some background on that?

Hon Mr Clement: Yes, and certainly this is one of the areas where you try to take a stab at it in terms of estimates, but if there's a disease outbreak you do what you have to do. So it's more of a placeholder than anything else. If the good doctor could elucidate that, I'd appreciate it.

Dr Kurji: Basically, much of that increase can be attributed to the increase in the price of vaccines. Our five-year contract with one of the manufacturers came to an end. Unfortunately, there has been a significant price increase and, whilst I haven't actually found the exact figure in my binder, it's close to $8 million. So that would account for a good portion of that increase.

Mr Miller: Why are vaccines increasing in price so much?

Dr Kurji: Unfortunately, when you look at the world prices for vaccines, they have actually been going up. In this instance, we do not have the luxury of competing with other manufacturers, as the appropriate manufacturer is really a sole supplier of those particular vaccines.

Mr Miller: Also on page 117, the Ontario breast screening estimates: I see in 2000-01, it was $19 million, then the estimate for last year was $32 million and $21 million was actually spent, and the estimate for this year again is $32 million. So there has been a substantial increase. Can you talk about that program a bit?

Hon Mr Clement: Yes. I know part of it is in terms of the number of facilities that are actually up and running. It's my understanding that as that number increases, we are closer to the targets we had expressed for ourselves. Dr Kurji, if you want to talk about that.

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Dr Kurji: Basically, again, this particular program isn't completely fully operational. The overall target was to screen 70% of eligible women between 50 and 69 years of age every two years, resulting in approximately 350,000 screens per year. In 2001-02, the program screened 169,520 women at 88 sites. In 2002-03, the program expects to increase this number by 25% and also to add 11 new sites to the program. The minister correctly alluded to the fact that the program isn't fully operational and we continue to increase the number of sites and we continue to increase, through CCO, the number of women who access this particular program. So when fully operational, it would actually be utilizing the full amount that has been budgeted.

Mr Miller: I know there has been talk in the budget of doubling the number of nurse practitioners. Where would I find the nursing estimates in the estimates binder? Maybe talk a bit about the nursing strategy as well.

Hon Mr Clement: That sounds like a Mary Beth Valentine question.

Ms Valentine: Perhaps I'll just talk about the strategy for a couple of minutes while we find the exact line, if that's appropriate, Minister.

Hon Mr Clement: Sure.

Ms Valentine: On the nursing strategy, just to perhaps refresh your memory, there was a task force in 1998, and the task force report came forward in 1999, with the government accepting all the recommendations. Progress has been made on the nursing task force strategy on a number of fronts. There were a number of areas, so there's not a single line within the estimates. It relates to—and I think the minister mentioned it in his opening comments—the more than $800 million that has been put into new nursing positions, for instance. In addition to that, of course, is the recent $3 million related to nurse practitioners and the new positions that will be created in long-term care.

There's also a specific recommendation related to improvements in nursing. In fact, we have a nursing research unit that was established. It has two sites: at McMaster and at U of T. There is $1 million in base funding that is provided each year, and recently an additional announcement of $1 million to enhance the research related to nursing human resources over the next two years. Actually, some excellent work has been going on there, some work that has been published to date that is being recognized, not only across Canada but in other jurisdictions, as being very forward, looking at predictive modelling and so on. It is primarily related to hospitals to date but is expanding, trying to look at other areas as well. A number of other research components are looking at effectiveness, utilization, nursing outcomes and so on, so we will see more and more results over the next year or so, that type of research that's going on.

On the issue of continuing and clinical education and recruitment and retention, there has been an investment of $10 million annually that has gone into those types of activities. The way that money is handled is that it flows, generally speaking, to the RNAO and the Registered Practical Nurses Association for a number of activities that they undertake related to recruitment and retention; everything from things like job fairs to developing specific tools to support recruitment and retention. There was an additional announcement, I believe in this fiscal year, of $400 million related to the development of tools and strategies related specifically to community care. Again, the first focus had been on hospitals, then long-term care. The minister's announcement at RNAO, as I recall, was for another $400 million related to community care.

There has also been over $70 million in new funding since 2002 to support the commitment to move to the baccalaureate and a more recent announcement of $50 million that I believe was raised earlier as well. So those

are, in summary, the types of investments that have continued to be made with the nursing strategy.

The specific $3 million is on page 71 and it is in the vote of the underserviced area plan. It is about three quarters of the way down the page.

Hon Mr Clement: In column B.

Mr Miller: That's the change; there's $3 million. Very good. Thank you very much. I see there's substantial investment going into nursing and a comprehensive strategy.

I just have one quick question to do with Parry Sound, if I could ask about it. It's not specifically—although maybe it is a budget item. I know in the Parry Sound area there's a beautiful new hospital, a $65-million investment going on. The groundwork was done, I believe, over the summer but they're in the process right now of waiting for permission to tender. They're quite keen about trying to get going before the snow flies and also to meet the commitment that the hospital has to have long-term-care beds open by 2004. So there's some concern in the community about getting the approval through so they can start work this fall.

Hon Mr Clement: Sure, we'll talk to that. My basic understanding is that there still is a little bit of a disagreement on the size and scope of one of the areas, if this is the hospital that I'm recalling correctly. I know we've been in discussions to resolve that issue.

Mr Stolte: David Stolte from the health reform implementation team. I can elaborate on that. The initial approval for the project was granted in August 2000 and that was an approval of the preliminary design at the functional program stage. What that approval enabled was the design and building of a new hospital that will replace the two current outdated hospitals in Parry Sound, a consolidation of services on one site.

There has been a lot of progress since then. The hospital has progressed through detailed design to the pre-tender, as you have indicated. They have completed some site work that could be done in advance of the design being completed. As well, in May 2001 they received an award for an additional 60 long-term-care beds. What the hospital did was, they revised their design to incorporate a co-located project of hospital and long-term care. In doing so, they identified an increase to the hospital budget that is, in their assessment, based on the additional long-term-care beds. The ministry did not accept the hospital's initial allocation of costs between the hospital component of the project and the long-term-care component of the project.

Based on that, the hospital has reworked their submission and resubmitted. They have revised their allocation of costs between the hospital and the long-term-care component and at this stage we're reviewing that submission. As well, the hospital is revising its local fundraising plan since it involves extra costs and it would involve more money to be raised locally. So those are the two current pieces that are going on right now and there's been a lot of progress.

Hon Mr Clement: Do we have any timelines, given the snow is going to fly at some point? Do we have any timelines yet on that, David?

Mr Stolte: We're close to agreement, and I think that when the government and the hospital can identify the share, we'll be ready to move forward on that.

Mr Miller: Thank you. I'm glad to hear that you're working on getting an agreement.

Mr Chudleigh: Minister, I see that our air ambulance budget has increased about $18.9 million on a new contract. I wonder if you could comment. I understand this is a new contract and a very efficient one. I wonder if you could explain why this is money so well spent.

Hon Mr Clement: Certainly. I'll defer to some of the experts. I had the opportunity to meet with some of our air ambulance professionals, and I can tell you that the kind of service they're offering in terms of quick response—and a lot of this involves things like road accidents, those kinds of things—I tell you, the ability of them to transport an injured person or some other afflicted person quickly and efficiently is probably the envy of many other jurisdictions.

So with that little advertisement, I'll just ask Gail Ure to elaborate on what we're doing in this area.

1730

Ms Ure: A couple of things. In terms of the money that is in the estimates, $1 million is for the critical care transport air ambulance. It's an annualization of previously approved amounts. The second part is $18.9 million for air ambulance, and that's broken down into basically three parts: about $5 million for the critical care contract, which is both fixed and rotary wing; $10.4 million for standing agreements. Part of this is looking at ambulances as part of the glue that fits the system together. If there's a decrease in physicians and specialists, then air ambulance many times has to carry people. So there's increased volume, increased air miles flown, increased fuel costs. The residual of that $18.9 million is due to fuel costs.

In terms of the program in general, the program was initially developed in 1977. It's one of the largest in North America at this point. When you look at the volume, they've flown approximately 17,000 patient transfers in 2001. It really does play a vital role, not just in the north but throughout the whole province. We count on them to deliver a wide variety of services.

We have a medical air transport centre and air dispatch, and that has to be intimately linked with the other land ambulance services, because it's one thing to get to the airport, but how do you get the rest of the way to the hospital or the treatment venue? That's also integrated.

Mr Chudleigh: Do many hospitals have helipads as well?

Ms Ure: A number do, yes, and that's part of the redevelopment that's going on that you heard about earlier today.

The Chair: We now go to Ms McLeod from the official opposition.

Mrs McLeod: Just to lead off, Mr Speaker—

The Chair: Sorry, the NDP has advised they won't be available, so we're splitting the time, as required, that's available. So there's approximately 15 minutes, and then over to the government side.

Mr O'Toole: Mr Chair, I was just wondering if the allocation would be 10, 10 and 10?

The Chair: Well, the NDP aren't here, so 15 and 15.

Mr O'Toole: No, but I'm asking a question, Chair, if you don't mind for a moment. If they don't use their time and we don't use our time, they get 10 minutes. I'd be happy with that arrangement. I have another engagement some two hours away from here, at 7:30.

The Chair: I understood from your caucus that's what they wanted to do, so I think what you have is a saw-off here. They get 15 minutes and then we close up. Is that fair? Because otherwise we'll have to bring it to a vote.

Mr O'Toole: That sounds fine.

The Chair: OK. Go ahead, please.

Mrs McLeod: I just want to put three things on the record, two questions and one point. First of all, in response to the minister's repeated reference to Elinor Caplan as a former Minister of Health bringing in the independent health facilities: for the record, she did not bring in independent health facilities; she brought in the Independent Health Facilities Act. Its purpose was to regulate the independent health facilities which existed in the province and to stop their proliferation. It required that the minister had to grant licences and that those licences could be denied if the minister felt that an additional facility was not needed in the public interest. It also allowed for the preference to be given to a Canadian provider, a provision which the current government removed from that act. That's my point for the record.

My two questions which I'd like to table for information to be provided for the committee, and I will not comment until I in fact do receive the information in the future—one is on physiotherapy rehabilitation. There's an indication on page 52 that the rehab reform pilot projects have been cut or discontinued. There's an $800,000 deletion for that. I would appreciate the tabling with this committee of any evaluation which was done on those pilot projects.

Secondly, I would appreciate a report on the status of schedule 5 clinics: how many clinics there are and how many—

The Chair: For the benefit of research, is there an acknowledgement from the ministry that those reports can be forthcoming, or how should we proceed?

Hon Mr Clement: I'm sorry, can you—

Mrs McLeod: I just was asking that any evaluation of the rehabilitation reform pilot projects, which are apparently now discontinued, be tabled with the committee, and secondly, the status of schedule 5 clinics in terms of whether or not there have been increased or decreased numbers of schedule 5 clinics over the past year.

Hon Mr Clement: An increase in the number of clinics, you mean?

Mrs McLeod: The schedule 5 clinics. I'm just looking for a status report on numbers only.

Hon Mr Clement: Sure.

Mrs McLeod: Mr Chair, if I may just table, because we're into our last 15 minutes—

The Chair: Is there an acknowledgement from the minister that that's available information?

Hon Mr Clement: Yes.

The Chair: That's fine, because it helps the researcher to follow up.

Hon Mr Clement: Yes.

Mrs McLeod: Thank you, and my last question, again, is just for information. I would appreciate knowing the changes in policy in the home oxygen program that have led to a possible $6.5-million decrease in funding over the last two years.

The Chair: Is that also a request for written information, and is the ministry able to provide that?

Hon Mr Clement: Yes. I would want to state for the record that we certainly have been negotiating quite aggressively with the industry. I think they'd be the first to admit that. So it needn't be a case of service decrease just because there's a cost increase, if I could put it that way.

Mrs McLeod: I'm just seeking information.

Mrs Pupatello: I have three requests for information, so that once we get this info we could have additional questions of the minister. One is the renewal of the contract with Canadian Radiation Oncology Services in March of this year. The minister's spokesperson at that time indicated that the cost per patient is comparable to publicly run clinics. I'm hoping that the minister can detail the cost per patient in the private clinic as compared to the public clinics. There must have been some kind of a review that allowed his spokesperson to indicate that the cost is comparable.

The second request is for any studies or reports that the ministry has undertaken into the cost of for-profit delivery of publicly funded health services, and if you would have those reports tabled.

Finally, could you table the status of all of the health service restructuring plans that are out there, tell us where they're all at, how many are completed in full, how many are 50% along and what the status is of the various restructuring plans across the province? Thanks.

The Chair: Would the minister care to characterize whether that's something that's available or not, again, for the benefit of the record?

Hon Mr Clement: I certainly will undertake to use my best efforts to make it available, if it is in existence.

Mr Gerretsen: On page 28 in the ministry communications services plan there's a $1.6-million overexpenditure in the salaries and wages component. I would like to get the details as to how the extra $1.6 million was spent. I'll just leave that with you and you can provide that information.

I also read today in the Ottawa Citizen that apparently the individual who issued or wrote the report that was done for the Ottawa community care access centre has indicated to the council there that they're not prepared to release the report in light of your earlier comments about the public having a right to know as to what's in the

report, particularly when it's finished. I wonder if you have any comments, Minister, as to why that report should not be released at this point in time so that the people who paid for the report can know about it. Do you have any comments, quickly?

Hon Mr Clement: I can tell you that I'm meeting with the chair of that board in the next few days and, if I can surmise, he may be waiting to at least have the face-to-face conversation before he shares it with the community. So it might be just a matter of days.

Mr Gerretsen: OK. As far as the transfer of the supportive housing program from the Ministry of Municipal Affairs and Housing to your ministry, could you provide us with a list of the number of supportive housing units in the province, the organization that received the funding through this program, the number of individuals served, the monies received by the organization and how many applications the ministry receives on an annual basis by individuals for supportive housing? I'm asking this in particular since I notice that in the budget documents that we were provided with the estimates there's absolutely no increase in the amount that you're allocating for supportive housing. Do you have any comments on that, sir, and can you provide the information I requested?

Hon Mr Clement: Again, certainly the general comment is that we are on the cusp of a groundbreaking series of reports on mental health implementation. We sought as a ministry to get all of that information so we can coherently start allocating new monies according to a plan rather than without a plan. So that's the short answer to your question.

Mr Gerretsen: But in the meantime, there's no additional money being allocated to this area.

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Hon Mr Clement: Mr Gerretsen, I think I explained to you the reasoning behind that.

Mr Gerretsen: When do you expect to have the report ready on that, or when do you expect movement in that particular area?

Hon Mr Clement: Certainly we are in the midst of receiving these reports. I think Gail Ure indicated that there will be a general report that will be available, as opposed to the individual reports, by December—oh, was it Mary rather than Gail? It's all becoming a bit of a blur.

Ms Kardos Burton: Thank you very much, Minister—"a blur."

Hon Mr Clement: No offence. Present company excepted.

The strategy behind that is obviously we want a road map. We want to look at this so that the patient is served to the best of our abilities, in an area, quite frankly, that has been ignored for many, many years. I'm not saying that in a partisan way. I think all three political parties that currently exist in the House would agree this is an area that needs our consideration and our focus. But in order to do that coherently and successfully, you need the plan, and that's what we're in the process of receiving.

Did you want to mention something about supportive housing?

Ms Kardos Burton: Yes. I just have a couple of comments to add to that. First of all, in terms of supportive housing, we do offer programs for supportive housing for mental health clients as well as seniors in this province. Last year, we actually overspent in this area.

But to respond to your specific question in terms of the programs that we offer, we can provide you with that information. When the minister was speaking about the previous information, it was December that Gail Ure said the mental health task force reports will come in. So we will provide that for you.

Mr Gerretsen: In light of the fact that $50 million less was spent than allocated in the community services area, could the ministry provide us with a list of the long-term-care community support services that are available to the elderly people in their homes and the number of services provided by each region across the province?

Ms Kardos Burton: There are 750 community support services agencies, but we could certainly provide you with some information in terms of what is available. I think you probably know the main ones are Meals on Wheels, respite services and those kinds of services. But we can certainly endeavour to provide something on a provincial basis, on a regional basis, for you.

Mr Gerretsen: Next, can the ministry provide a breakdown of the new beds in the long-term-care facilities by location, owner-operator, dollars invested per facility, number of beds committed, whether it's a new facility or an addition to an existing facility and the total number of beds for that facility, the date of completion or the projected date of completion. Could you also provide the same information with respect to the redevelopment of the beds in existing facilities. Is there any problem with that?

Mr Mazzilli: That's why they overspent—

Hon Mr Clement: This answers the question on additional staffing, right? That's right.

OK, we'll do our very best for you on that.

Mr Gerretsen: Next, we talked about accountability earlier, Minister, particularly when it comes to long-term-care facilities. You indicated that there are 40 compliance officers. We have over 550 long-term-care facilities, I believe, in this province. How often does the average facility get inspected?

Hon Mr Clement: I'm sure the short answer is that it depends, because certain facilities—

Mr Gerretsen: On average, would you say once a year?

Ms Kardos Burton: Yes, I'd certainly say that, but it does depend on circumstances. Facilities that are receiving complaints get inspected more often.

Mr Gerretsen: But I think from reading some previous documentation as it relates to the Provincial Auditor's report, as well, a few years ago, most facilities get inspected no more than once a year.

Do I take it, then, that the ministry is totally relying on the compliance aspect of making sure that inspections get

done, on making sure that the facilities comply with the rules and regulations that are out there? Collectively, all of us are relying on basically one inspection per year to make sure that the facilities are following the rules and regulations that are out there.

Hon Mr Clement: Again, Mr Gerretsen, with all respect, I think it depends on the facilities and on their track record. Clearly there is greater oversight on those that have had a record of complaints or a record of concern; of course those receive greater oversight.

Mr Gerretsen: How often would you inspect the facility that you inspect the most: on a daily basis, on a weekly basis, on a monthly basis? Is it purely based on complaint? Do we ever make any spot checks to make sure that the rules and regulations are followed? In most cases that I've heard about, certainly the operators or the people who run the home know when the inspector is coming in. What comments do you have on that?

Ms Kardos Burton: If I could just go back to the complaints, first of all, every complaint is investigated by ministry staff within 21 days, so we certainly wouldn't wait until the next time we were going into the facility. If there are serious complaints—all complaints are serious, but obviously it would be investigated immediately. There have been situations recently, and I think the minister alluded to it earlier, where we had complaints that were given to us by our compliance advisers and the inspections people were in on a daily basis.

I also think it's important to know that we have a system of seven regional offices throughout the province, and our regional office directors and program consultants work very, very closely with our long-term-care facilities. So it isn't just the complaints process that we rely on; it's also an ongoing operations management program supervision.

Mr Gerretsen: OK. So if there are no complaints, on average how often does a facility get inspected?

Ms Kardos Burton: I think, again, that depends, but certainly at least once a year, as you mentioned.

Mr Gerretsen: OK.

Ms Kardos Burton: I do want to stress the regular contact that we have with the facilities and also the reporting that comes in. So even if it wasn't a compliance adviser, your regional office staff would be in contact with the facilities.

Mr Gerretsen: Finally, in the last minute that I have, I have one more question relating to integrated health care, and this is from a statement that is made in your estimate document. Under community support services, would the ministry provide a breakdown of services "for which clients may pay a fee": who determines if a client will pay a fee, how is the determination made and the number of paying clients in that area? Do you have any problems providing that information?

Hon Mr Clement: I'm sorry, I missed the first part of your comment.

Mr Gerretsen: A statement is made in the integrated health care portion of your budget. Would the ministry provide a breakdown of services—and this is your statement—"for which clients may pay a fee"? What I am trying to determine is who determines if a client pays a fee, how that determination is made, what kind of services we're talking about and the number of fee-paying clients in those particular services.

Hon Mr Clement: Certainly we will provide that information. I'm not quite sure where you're reading from, but we'll get the information for you.

Mr Gerretsen: I'm just reading from my own briefing notes.

The Chair: Perhaps that can be clarified for better follow-up.

We are now concluded in terms of time, and by arrangement the government caucus is not proceeding. We now turn to something that should be of interest to the minister, which is voting on the allocation for the ministry. The first vote should be of interest to the assembled because it is for the ministry administration. I put the question. Shall—

Mrs McLeod: Mr Chair, can I just have a question before we get into voting?

The Chair: Yes.

Mrs McLeod: Would the ministry be able to tell me what vote the supportive housing for the physically disabled might come under?

The Chair: Can I have an indication, please, from the ministry, on a volunteer basis, which vote is supportive housing.

Mrs McLeod: For the physically disabled.

The Chair: Which is the major heading? Do you know? I'll tell you what, I'll read the vote out so you know the major heading, but we have to proceed without further discussion.

Vote 1401 is ministry administration. Shall vote 1401 carry? Carried.

Vote 1402 is health policy and research. Shall 1402 carry? All those in favour, please say "aye." All those opposed will say "nay." I declare the motion carried.

Vote 1403 is for smart systems. Shall vote 1403 carry? I declare it carried.

Vote 1404 is for integrated health care programs, which I cannot but mention is worth over $9.8 billion. Shall vote 1404 carry? All those in favour, say "aye." All those opposed, say "nay." I declare the motion carried.

Vote 1405 is for OHIP. Shall vote 1405 carry? The motion is carried.

Vote 1406 is for public health, health promotion and wellness. Shall vote 1406 carry? All those in favour, say "aye." All opposed, say "nay." The vote is carried.

Vote 1407 is for health capital. Shall vote 1407 carry? The motion is carried.

Shall the estimates of the Ministry of Health and Long-Term Care carry? The motion is carried.

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

Thank you very much. I want to thank all the participants. It was by special arrangement that we met this full day.

For the committee members, there is a motion to follow regarding our next estimates, or the one after that. I'll ask the voting members to stay attentive for that.

I do want to thank the minister and the participants for this session today.

Mr Chudleigh: On a point of order, Mr Chair: I'm going to move the motion of the subcommittee.

The Chair: That's what we want to do right now.

Mr Chudleigh: I have to read it in.

The Chair: Would you like to move that motion?

Mr Chudleigh: I have to read it into the record.

The Chair: I'll be happy to read it for you, or you're welcome to, whichever you like.

Mr Chudleigh: Your subcommittee met Tuesday, September 10, 2002, and recommends the following with respect to consideration of the estimates of the Ministry of the Environment and the Ministry of Energy, formerly the Ministry of Environment and Energy:

(1) That the time allocated be split evenly, ie, three hours and 45 minutes for the consideration of each ministry;

(2) That the time allocated for the opening statements be limited to 15 minutes for each recognized party and the ministers be allowed not more than 15 minutes for their right of reply;

(3) That the estimates of the Ministry of Energy be considered first, subject to the minister's availability.

I move the report of the subcommittee.

The Chair: Thank you for the report.

Is the report of the subcommittee accepted? Agreed? Any opposed? OK.

Thank you very much. We'll see you on the 24th.

The committee adjourned at 1752.

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