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Tuesday 5 October 2004

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Mardi 5 octobre 2004

Standing committee on estimates

Ministry of Health
and Long-Term Care

Comité permanent des budgets des dépenses

Ministre de la Santé et des Soins
de longue durée

Chair: Cameron Jackson
Clerk: Trevor Day

Président : Cameron Jackson
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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON ESTIMATES

COMITÉ PERMANENT DES BUDGETS DES DÉPENSES

Tuesday 5 October 2004

Mardi 5 octobre 2004

The committee met at 0906 in room 151.

MINISTRY OF HEALTH AND LONG-TERM CARE

The Chair (Mr Cameron Jackson): Good morning. I'm pleased to call to order the standing committee on estimates. We are currently with the Honourable George Smitherman, Minister of Health and Long-Term Care. We have five hours and three minutes remaining.

In our normal rotation, does the committee wish to use 15- or 20-minute rotations? I'm open to a suggestion. When we last did it, they were 10 minutes, so tell me what time frame you would like. Twenty minutes? I'm hearing no objections. Fine. Please proceed, Mr Baird.

Mr John R. Baird (Nepean-Carleton): Minister, I want to come back to the issue of hospital funding. There are 150-odd hospitals in the province. Many are having significant concerns and problems. I wanted to talk about two hospitals that I know best, but it could just as easily be the London Health Sciences Centre, a hospital here in the greater Toronto area, Hôtel-Dieu in Windsor or a hospital up north.

I want to come back to two hospitals that I know best, starting with the Queensway Carleton Hospital, which, some five to five and a half months into the fiscal year, discovered that they are only receiving a 0.6% budget increase. Health care inflation, according to the Ontario Hospital Association and its president, Hilary Short, is running well in excess of 7%. The hospital put in a somewhat modest request, below the rate of health care inflation, of between 4.5% to 5%. Five to five and a half months into the fiscal year, when they've already spent almost half their budget and when they have a requirement to give a six-month notice of any layoffs, due to the collective agreements that are negotiated centrally, and given that 75% to 80% of their costs are labour, what sort of advice would you have for them at the Queensway Carleton Hospital about what they're to do with a 0.6% budget increase?

Hon George Smitherman (Minister of Health and Long-Term Care): I think the member will know by now that his repetitive use of that figure—notwithstanding that it's not an accurate figure.

The first point I want to reiterate is the point I made yesterday, and that is that Ontario hospitals were provided with a significant amount of notice about expectations for this coming fiscal year. We did that, frankly, in response to the realities that we were confronting as a new government, a government that had the residuals, the left-behind legacy of fiscal mismanagement that is now the legacy of your party.

The fact of the matter is that, on the issue of hospital funding, not only were we confronted with the challenge as a new government of providing $385 million in a deficit bailout, we were a government that was struck—or perhaps I should say stuck—with the reality that, under the direction of a former Minister of Health of your government, hospitals were directed to bury unpaid operating bills from two fiscal years in their working capital deficits. This is a number that's well beyond the work that the former Provincial Auditor did. We further acknowledge that those directions from then health minister Tony Clement to hospitals buried a further $721 million in unpaid operating bills from two fiscal years in the working capital deficits of hospitals.

On February 24, I had the opportunity, in what I think would be characterized as a major speech to the Economic Club of Toronto, to highlight to hospitals that the outlook for the 2004-05 fiscal year was one where the double-digit increases that had become the norm in hospital funding should not be the expected norm, that it wasn't an appropriate operating mentality or expectation given the fiscal challenges that we were confronting, and particularly given the reality that, as a government, we are inclined to move forward in a different approach than your government followed, which was all the money for hospitals and no money for community. Instead, we viewed that it was important to make a financial contribution in the health care sector, addressing it and recognizing it for its entirety as a sector. So we brought forward a budget subsequently that did a few things.

It put $469.5 million of new funding into Ontario hospitals. This is, again, on top of the $385 million which we had, only a few short months before, provided. In addition to that, it made the single largest investment in community-based care that had been seen in Ontario, some people tell me, in its history. That included a $600-million investment over four years for primary health care reform; the construction of family health teams, something that we're really excited about; a $103-million expansion to home care; $29 million for community support services; and a variety of other initiatives which were designed to create a health care system that was

more in balance—and all of these community investments designed to help take pressure off hospitals.

The Queensway Carleton Hospital that you refer to quite specifically in your question has been the recipient of four or five different funding contributions from our government this year. The original amount had a slight clawback associated with it because Queensway Carleton missed hitting some volumes that they had committed to. In addition to that, though, they received $2.7 million in one-time funding. In September, they received an additional top-up of $440,000. Then they were awarded $6.3 million, for a total of $7 million. Then they got $800,000 for the operation of an MRI. Now, I know that's an MRI that you're very sensitive to because you announced it. But I just want the record to show that while you might have announced it, we're the government that actually found the fiscal wherewithal to pay for it.

My point here is that the Queensway Carleton, in a letter that was printed on September 30 in the Ottawa Sun—the chair of the board sent this letter: "On behalf of Queensway Carleton Hospital's board of directors, I wish to thank Premier Dalton McGuinty and Minister of Health George Smitherman for the official confirmation that the Ministry of Health and Long-Term Care will initially invest $6.3 million to allow QCH to begin ramp-up of services in our new expansion; an expansion which will allow us to continue our excellent record of health care delivery through an enhanced and expanded emergency department, a new 12-bed intensive care unit, more in-patient medicine and geriatric and rehabilitation beds."

I just want to make the point that there's no doubt whatsoever that we face extraordinary challenges on the hospital-funding file. The public record is loaded with references to our acknowledgement of the incredibly great work that our hospitals do. Like everybody else in health care, including governments, it's a struggle. But it is a struggle to provide care in all parts of the health care sector. The approach that we've taken is one which is really designed to recognize, for the first time in a long time, that we're all in it together, that different parts of the health care system need to function in order to take pressure off our hospitals. So we believe that these things combined—

The Chair: Thank you, Minister.

Mr Baird: I'll go through these numbers.

The operation of the MRI, the $800,000: Obviously that will have to go toward operating the MRI, not to the baseload of services that the hospital provided in the last fiscal year.

The $6.3-million operating costs for the expanded QCH is obviously tremendously important. It doesn't go all the way to funding the new wing at the QCH, but, again, it doesn't affect the operation of the hospital, the core set of services that they had to provide last year.

The budget increase, according to your ministry, according to the hospital administration and according to the hospital board, was a base increase of 0.6%, so I want to talk very specifically about the set of core services that got a 0.6% budget increase and what your expectation is, as minister. We were five and a half months into the fiscal year when you made the announcement. They can't retroactively go back and cut expenses for the nurses, the gentleman that pushes the broom, the woman who works in the cafeteria and the secretary who works in administration. They can't retroactively go back and open their paycheques. They're required, on a go-forward basis, to give six-months' notice of a layoff, if they can find an efficiency. I would argue that with the operational review conducted by your ministry some two and a half or three years ago, they've implemented just about all of the requirements there.

So I want to come back, very specifically, to this point: How do you, as minister, expect them to deal with that? I'm sure that there are many people who would welcome the wide array of investments you've outlined in other areas. But for this hospital board, they're facing a challenge. Do they cut services? Do they run a deficit? Or do they seek your wise counsel? What can I tell them that you specifically said for them to do in this regard?

Hon Mr Smitherman: I'd say first off that I don't think you need to tell them anything, in the sense that Ontario hospitals, I think, are in a very clear understanding about what their obligations and responsibilities are at the moment. I want to make a few points.

First, hospitals have 18 months to get in balance. What we've looked to do is move beyond the declaration-of-crisis point, which is the culture we inherited from your fiscal management. That is a cycle that I think everybody in their quiet moments is prepared to acknowledge as being a very problematic cycle.

I didn't have the benefit of being at your cabinet meetings but I have had the benefit of speaking to some former cabinet ministers from your government who have acknowledged that hospital funding is one of those struggles that really did bedevil the former government in its last five years, and particularly the contribution you've made, that I don't think you should escape, to the culture that was created. The culture that was created was one that is not viable. It is not a viable premise, when all of us are obligated to live within what is allocated to us, to send another bill along at the end of the year and say, "Please pay this as well." So we've initiated changes in the way we're going to fund hospitals.

Hospitals came back and said, "We've got some work to do. It's going to be challenging," which we all acknowledge. So they said, "Give us 18 months to get the job done." We've extended the balance period to the end of 2005-06. That provides a little bit more opportunity for people to make the right decisions.

The second point that I think is important to make—and it's not a point that you were, I think, in sync with yesterday—is that we are in an era of restraint as it relates to health care spending and as it relates to labour costs related to health care. No doubt about it, this is a message that has been sent strongly and it needs to be sent repeatedly. The reality is that we can't afford, in our province, to pay a lot more for what we already have if

we're going to be able to meet the expectations of expanding services.

I'll make the point as well that in less than a year in office our government has introduced $854.5 million in new base funding to Ontario's hospitals—nearly $1 billion in less than a year in office. I think that's a significant number that needs to be considered here. Just before the numbers for 2004-05 were allocated, we had just brought their base budgets up to a level of their last day of 2003-04. In other words, they started the fiscal year at a very high number, just having had a significant injection of new resources. Further, we've acknowledged $721 million in debts that are the leave-behind and legacy of your party while in office.

This is where we're at today: By 15 October, Ontario's hospitals will begin to file plans with the Ministry of Health which indicate the steps they have taken, that they have under consideration or that they may need to take in order to be able to get their budgets in balance.

I had a good meeting last Friday with the board chairs and vice-chairs from the Ontario Hospital Association. I think we're in a very clear understanding that we've all got some more work to do. If you go back to my announcement in July, what I said then and what I'll repeat now is that the ministry is going to deal with these on a case-by-case basis and work them through. We know there are some challenges out there, for sure, and we're ready to bring all the best advantages of the health care system to help.

What I mean by that is that if there's a hospital, as an example, that's struggling to come in balance or what have you, and we have good role model hospitals that have gone through some of the same tough things and got to the other side, then we're going to bring those forces together and make sure the system helps the system. My point here is that we're going to work our way through these challenges and assist local community hospitals all across the province to get books in balance and to create a sense of fiscal stability related to the hospital sector, which I can assure you is essential for all of us to make medicare in our province sustainable.

Mr Baird: In your judgment, is it acceptable to run a deficit this fiscal year for hospitals in Ontario?

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Hon Mr Smitherman: Hospitals know that what's expected of them is to get in balance by the end of—

Mr Baird: I hear you on that, but is it acceptable for hospitals like the Queensway Carleton, under your tenure as Minister of Health, to go into deficit this fiscal year?

Hon Mr Smitherman: The only situation in which it's going to be appropriate is where there's a plan in place overall to have the books in balance by the end of 2005-06.

Mr Baird: So you want to say it's acceptable this year.

Hon Mr Smitherman: I know what your question is. I'm not going to sit here and condone deficits.

Mr Baird: Isn't that what you're doing?

Hon Mr Smitherman: I am not going to condone deficits; no. What I'm going to do is recognize something that while your party was in office you seemed to have a bit of a difficult time with, and that was recognizing that it was—

Mr Baird: You seem to be having a difficult time too.

Hon Mr Smitherman: I think, with all due respect, it's a little early for judgments. I think we're making a lot of progress. As I said, I guess I had the advantage of a good meeting that took place on Friday out at the airport with the OHA board chairs and vice-chairs. I think we're going to work our way through these. There's no doubt whatsoever that some Ontario hospitals are going to need more help, more practical assistance, and we're ready to go in there with our equivalent of turnaround teams and assist them in any way we can.

Mr Baird: What do you say to hospitals that have already had turnaround teams, that have had operational reviews conducted by your ministry, have found efficiencies, where operational reviews conducted by your ministry have gone in and said, "Wow, the group of men and women running this hospital are running an efficient show. Yes, they can find a per cent here or a per cent there, but by and large they're doing a good job"? Or a hospital like the Ottawa Hospital, where they cut 5% of their budget after that review and run a more efficient operation?

Hon Mr Smitherman: I think that's evidence that we're going to have a good chance on a case-by-case basis to review, and I'm really looking forward to it.

Mr Baird: But what is the expectation of those hospitals? One of the reports that your ministry commissioned identified the top 25% of hospitals that you could characterize as being good fiscal actors who operate efficiently and, if you could get the bottom 25% to adopt those standards, what sorts of savings could be achieved. But what do you say to those top 25% of hospitals that are being run efficiently? They might be paying some sort of price for operating efficiently in recent fiscal years now that the budgets are becoming tighter. Those hospitals are getting well below the average and you're giving—what?—4.5%, 4.6% on average to hospitals, but some are getting substantially lower than that, such as the hospital in my riding and in Mr McGuinty's riding.

Hon Mr Smitherman: I think the evidence is there. This is an evidence-based process, much more than at any time in the past, and a lot of the funding decisions that have been made are based on a funding rationale that's been developed, working between the Ministry of Health and Long-Term Care and the Ontario Hospital Association through something called the JPPC. The J is the operative letter because it means "joint," and the P means "planning."

On lots of these issues with respect to the rationales related to who gets what and when, we've been working on this using peer group data from I think 16 or 18 different hospitals and measuring against that. It's a complex funding formula, for sure, but my expectation—and I think that's the question you've asked—is that the

boards that are responsible to govern these hospitals will play their role and fulfill their obligations to provide information to the ministry; that on a case-by-case basis we're going to work through and determine what kinds of steps might be necessary for any of those hospitals that are having challenges.

I will note that just one very helpful short example would be Guelph General. Guelph General is a hospital that was facing a deficit. By memory, I think it might have been $2.3 million. They did a bunch of hard work and made some very tough choices, but at the end of the day they've been able to make decisions and cast a budget for the fiscal year and for the period going forward that allows them to hire more nurses and stabilize the quality of their workforce.

Mr Baird: What budget increase did Guelph General get? Did you give them 0.6%?

Hon Mr Smitherman: I'll get you the number.

Mr Baird: I'm going to bet, Minister, that it was more than 0.6%. It would make it easier to balance your budget if you were to get more money.

Hon Mr Smitherman: Well, your hectoring notwithstanding, I think it's important to note that I told you earlier that the numbers you were constantly pumping out there are artificially low, and I think you know that.

Mr Baird: No, I don't know that. That's the number the hospital gave me. That's the number on your own ministry documents for the baseload of services they provided last year. Last year they didn't operate an MRI, so they didn't need the $800,000 because it wasn't operational; this year they do because it is operational, because your ministry gave them the green light to go and purchase it. But last year they didn't have a requirement for $8 million in new operating funds because their expansion was under construction and there were no nurses providing care in that hospital. So I'm talking about the baseload of services that were operated last year that require operation this year for people in my community.

Hon Mr Smitherman: I guess you haven't spoken with the hospital quite recently enough, but—

Mr Baird: I spoke to them yesterday.

Hon Mr Smitherman: Well, then, they forgot to mention that they got an additional $440,000 in September that goes into base, and—

Mr Baird: Is that going from 0.6% to 1%? Because they haven't seen that money.

Hon Mr Smitherman: If they haven't seen it, they're certainly aware of it, because—

Mr Baird: But they haven't seen it. They have to meet a payroll, Minister, and they haven't seen the money, and if they don't get the money, they can't meet their payroll.

Hon Mr Smitherman: With all due respect to your supposed knowledge about the cash-flowing operations of Ontario hospitals, if the hospital's in a situation where they're having difficulty meeting a payroll, as does occur in Ontario hospitals from time to time—

Mr Baird: Yes, when they get 0.6%. They have trouble getting the payroll—

Hon Mr Smitherman: —they know that the ministry's regional office is prepared to assist them if that's the circumstance, or the board chair or the hospital CEO can be in contact.

In all instances, the real message here is that there are lots of challenges we face across the breadth of 154 hospital corporations in the province of Ontario at any one time. Some of them are struggling. That's very, very clear.

Mr Baird: They're struggling because they get 0.6%.

The Chair: Mr Baird, that's the end of this round.

Hon Mr Smitherman: It's important, if your hospital is having those challenges, that they be in touch with the regional office.

The Chair: Ms Martel.

Ms Shelley Martel (Nickel Belt): I want to return to the questions on long-term care that I began yesterday. Minister, I specifically want to start with the election promises that were made by your party with respect to long-term care. In your health care document, on page 10, you were really critical of the former government for removing standards of care in nursing homes. You said specifically what the Harris-Eves record on seniors showed: "Removed standards that made sure all nursing home residents received at least 2.25 hours of nursing care daily and three baths per week." You said that you were going to "set high standards for our nursing homes and regularly inspect them to make sure those standards are being met."

We discovered yesterday that, although you made an announcement about bathing regulations in May, those haven't been passed yet and you expect them to be passed in about six weeks. Then I'm quite sure I heard you say that you were not going to be implementing a minimum standard of care for nursing homes, but I wonder if you could just confirm that for me as I start this line of questioning.

Hon Mr Smitherman: I can confirm it or—I answered the question—

Ms Martel: Are you going to reinstate the 2.25?

Hon Mr Smitherman: I answered the question yesterday directly, and I'm pleased to answer it again.

Ms Martel: OK, let me just confirm again. Are you going—

Hon Mr Smitherman: No.

Ms Martel: So in fact you don't have any intention of keeping the promise you made in your election document, even though you were quite critical of the former government for cancelling the 2.25 hours of nursing care. I certainly remember Mr Gerretsen calling for a reinstatement of that. I heard Ms McLeod call for a reinstatement of that as well when you were in opposition.

Can you tell me why, now that you're in government, you are no longer interested in implementing a minimum standard of care, even though you were very critical of the former government when they cancelled it?

Hon Mr Smitherman: I'm very pleased to tell the honourable member, who seems to have missed some of the action on this file in the last year, to recapture that. Here are the circumstances that we encountered upon taking office. There were stories on almost a weekly basis of serious concerns related to the quality of care being provided in our long-term-care residences. This came through in a fashion that was emotionally impactful for many, of course.

My parliamentary assistant, Monique Smith, went about the province doing a series of unannounced visits to long-term-care homes, as did I. She met with stakeholder upon stakeholder upon stakeholder and produced a report that has been, I think, if not universally then awfully well acknowledged to be a document which captured both the sense of the challenge that was out there and some of the best practices in place at long-term-care facilities, and developed a very direct go-forward plan to restore a level of confidence to meet what I like to refer to as an Ontario standard.

0930

On the issue of long-term care, I think that in the course of our government's path—11 months and a couple of weeks or so—we've dramatically reformed the long-term care product in the province of Ontario.

How have we done that? We have done that through a wide variety of initiatives designed to drive the words "home" and "community" back into long-term care and to make sure that in the institutional environment that connection to community and culture and a sense of home and being was created for people who were living in those communities.

How did we do that?

Ms Martel: My question was minimum standards of care. That's the question I'm asking.

Hon Mr Smitherman: Standards of care certainly are among the elements of the package that we've moved forward on. Regulations that we discussed yesterday to restore a standard where there is 24-hour RN coverage and a minimum standard with respect to bathing requirements, are two very, very strong standards that are important. At the same time, we've also brought money. We've brought money in the form of $191 million annualized to improve the quality of care. We're putting our money where our regulations are.

To back up those enhanced regulations, we're sending 2,000 new employees to the front lines of long-term-care facilities in the province. That will consist of at least 600 registered nurses, who, as I mentioned earlier, will need to be on call 24 hours a day.

In addition to that, we've enhanced our enforcement and inspection capacities. The principle, the culture, of the unannounced visit is now the ongoing culture in long-term-care facilities in the province of Ontario.

Ms Martel: Let's stop there. Let's go back to the promise, because you were clearly critical of the former government for cancelling the standards.

If you take a look back in the last year and see some of the statements and comments made by two of your own colleagues, Mrs McLeod, when she was here, and Mr Gerretsen, you will see that they were very critical of the former government and that they repeatedly said that a Liberal government would reintroduce minimum standards of care.

In fact, Dave Levac, one of your own members, in February of this year at a meeting with SEIU in his community, said the government would have to go beyond that because it was clear that residents coming into long-term-care facilities had much higher needs.

Now you're telling this committee that, frankly, you have no intention of bringing in minimum standards of care.

It is true that Ms Smith met with stakeholders. Here's what some of those stakeholders had to say with respect to a minimum standard of care.

This is the presentation by ONA to Monique Smith on May 3, 2004, under the title "Immediate Actions."

"1. Interim base staffing levels

"The government must reinstitute, by regulation, a minimum staffing formula. We recognize that the pre-1996 formula of a simple 2.25 hours of care per resident ... does not make sense in an environment of levels of care classification where residents in different homes will require different amounts of care."

That's why they propose tying staffing levels to acuity and occupational levels.

They said, "Nevertheless, there has never been any justification for the elimination of the 2.25 hours...."

That's what they said.

CUPE, when it met, and as recently as last week in a press conference they had here talking about the situation in long-term-care facilities, said there should be a minimum 3.5 hours of nursing care per day per resident because of the increased level of needs of residents going into our long-term-care facilities.

SEIU, which also represents workers in long-term-care facilities—thousands and thousands, I might add—has also been very clear in calling on your government—and this was in their presentation to Monique Smith as well—that your government should implement a minimum staffing standard of 3.35 hours.

Those are the stakeholders, some of whom Monique Smith met with. These are the people, I remind committee members, who actually deliver the front-line care in our facilities.

ONA represents 3,500 RNs, RPNs and health care aides in long-term-care facilities. CUPE represents 1,000 workers in 18 facilities. SEIU represents thousands more.

These are the people who actually work with the residents every day and who have told Monique Smith and your government very clearly that what is needed is minimum standards of care and to ensure that money which goes into the homes actually goes into increasing the number of staff dealing with residents.

I should remind you, Minister, that even with your announcement of 600 new nurses, that works out to about one nurse per facility across the province. That one poor full-time nurse now being hired is not, despite his or her

best efforts, going to be able to make a huge difference in providing quality care to residents.

The 1,400 new front-line staff positions that this money is going to hire, that's maybe 2.25, maybe two, new full-time positions per day.

I regret to say that that is probably not going to meet the needs of residents who have seen their level of care drop to two hours a day directly as a result of the cancellation of minimum standards. That was clearly demonstrated in a government study funded by the Ministry of Health released in 2001. CUPE, SEIU and ONA, the people who represent front-line workers, have said that you need minimum standards of care, because if there aren't any standards of care in place by regulation, regrettably, too many operators will operate to the lowest common denominator and the lowest possible staffing level.

You and your party made a commitment to have minimum standards with respect to care, to have a regulation to that effect. Why won't you do that now, especially in the face of the call of front-line providers telling you that you should do that?

Hon Mr Smitherman: I think it's incredibly important to acknowledge that this is a file that has had a lot of work done on it since we came into office. I'm more proud of the progress we've made on long-term care than on any other file that I've had the honour and privilege as Minister of Health of putting my fingerprints on. I say that because I have had a chance to weigh a lot of information and I have had the opportunity to feel a community move.

You're obviously raising voices from people who are important.

Ms Martel: Front-line staff.

Hon Mr Smitherman: Pardon me?

Ms Martel: Front-line staff, who are providing care to these residents. Probably they know better than most about what they can do and what they need to improve that quality of care. What do their voices account for?

Hon Mr Smitherman: Is it a back-and-forth now, Mr Chair?

The Chair: I think you're handling yourself quite well, Minister. Please proceed.

Hon Mr Smitherman: I think it's important to recognize a few things that have changed as well. One of the things that we instituted related to accountability with respect to hospitals is the principle of a sign-back letter, where, when resources flow for a particular purpose, there is a sign-back that ensures their greater accountability. In addition to the regulation standards that we're putting in place with respect to making sure there is a registered nurse again in every one of our long-term-care homes 24 hours a day, in addition to the standard that introduces minimum requirements for bathing again, we're using the capacities and the accountability related to the sign-back letters, keeping in mind that we have new accountability agreement arrangement capacities as a result of our government's Bill 8 with respect to long-term-care homes. The funding letters go further in terms of defining the minimum expectations with respect to the quality of care that's provided in long-term-care homes in our province.

What you're looking for is a standard that is established only in regulation. What I'm looking for is a standard that is achieved through a combination of regulation, funding that is tied with accountability agreements and sign-back on funding letters, a new culture in long-term-care homes that has a much stronger mandated voice of family and resident councils, and a dramatically enhanced inspection and enforcement capacity. In the last year, inspections increased 61%. Complaint investigation levels have risen to 93%. This is evidence of the extent to which we've dramatically enhanced our enforcement capacity.

My message to anyone who is listening in with respect to long-term care is that as a government that faced a situation where we could not be assured that the quality of care being provided in long-term-care homes across the province was meeting an appropriate Ontario standard, as a result of the initiatives that we've been involved in, there is a much greater degree of confidence about that in Ontario.

But we are not going to rest on the work that we've done to date. My colleague Monique Smith did a good body of work, and part of the body of work that she did was helping us to home in on what legislative requirements might require change. I'm very pleased to say that we will have a piece of legislation with respect to long-term care. Public comment will be available on it shortly. It will, as an example, include something that front-line workers have been calling for, and that is significant whistle-blower protection.

0940

I also want to read back to you—you mentioned the Ontario Nurses' Association. This is a May 11 media release from the Ontario Nurses' Association. I'll provide a copy and the clerk can pass a copy out. "Nurses Say Senior Care Reforms Long Overdue." This was in response—you'll remember that bright sunny day on May 11—to our government's actions.

The first line says, "The Ontario Nurses' Association ... welcomes the provincial government's plan for comprehensive reform of the long-term care system, and urges its speedy implementation." I'll provide that to the clerk.

I think it is evidence that people on the front lines understand that as a government we're moving forward with comprehensive reforms with respect to long-term care that are going to give them a stronger voice, more workers to assist them on the front line, re-establish minimum standards, work through the accountability agreement powers that we have to establish further standards in areas of increased registered dietitian staff time per resident, increased personal support worker staff time per resident and an increased level of social programming provided by people in these facilities.

I think there's ample evidence that we've made significant progress on this, but we have more work to

do, including a piece of legislation, and I'm looking forward to bringing that forward to the House as soon as we can get it there.

Ms Martel: Let me quote them again, because this was their presentation to Monique. "I. Immediate Actions". The number one immediate action is, "The government must reinstate, by regulation, a minimum staffing formula....

"ONA proposes to tie staffing levels to acuity and occupancy levels. Increases in acuity and/or occupancy would result in proportionate increases in staff." That was their number one recommendation.

What I find interesting is that you're prepared to re-establish two of the minimum standards that were cancelled by the former government and not the third, even though I recollect very well any number of your colleagues saying that a Liberal government would. You're telling us that in six weeks we will finally see a regulation with respect to bathing and in six weeks we will, we hope, finally see a recommendation with respect to having an RN full time in every facility in the province, but you are backing away from the commitment that was clearly made by your colleagues and by you in an election platform with respect to minimum staffing levels.

Yes, I am looking for a regulation with respect to minimum staffing levels, because when there is a regulation in place, then you can have some enforcement. When there isn't a regulation in place, it's very difficult to tell a particular home, "You are not providing adequate staffing for a behavioural therapist, for a dietitian," etc. If you don't have those minimum levels in place, the result is going to be the same that we saw when the former government cancelled minimum standards, and that is, Ontario residents regrettably—really regrettably—at the bottom of the heap at all levels: in terms of direct hands-on nursing care, nursing interventions, interventions with respect to behavioural treatment, with respect to occupational therapy, physical therapy etc. Yes, I do want a minimum standard. That's what your colleagues wanted too before the election. That's in fact what your party promised before the election. And no, I don't understand why it's good enough to bring back two of the three regulations that the Tories cancelled, especially in light of the fact that those people who deliver front-line care—RNs, RPNs, PSWs, health care aides—are all calling on your government to do that.

What is the problem, Minister, in reinstating a minimum standard of care tied to acuity levels to ensure that every facility, every home operates to the highest standards instead of operating, regrettably, as some operators do, to the lowest when there is no regulation in place to force them to do otherwise?

Hon Mr Smitherman: A few points: First, you quote from a presentation to Monique Smith from ONA. Monique Smith files a really substantial report with me; we come forward with an action plan; ONA says, "Not so bad."

My point here is that I think it's incredibly important to recognize how much change has occurred, how much progress has been made on this file in reasonably short order, and how much more we've committed to do with respect to a piece of legislation.

One other thing that I think is incredibly important that you begin to consider is that as a government, something we did very early on, in a piece of legislation that you opposed, was create the mechanism for a very powerful new tool in the funding relationship between the government of the province of Ontario and those hundreds and hundreds of organizations that provide direct services to our patients, and that is accountability agreements. The point here is that we now have a tool that previous governments lacked in connecting our funding to the desired and achievable outcome. We believe that, on the basis of the things that we will restore in regulation, the new funding that we've put in the system—particularly given the fact that we've been able to, through the funding letters and subsequently through accountability agreements—we will be in a position to ensure that the dollars allocated to the health care sector for the kinds of care that we've been talking about for the last 10 or 15 minutes are delivered. The effect of this will be that we will achieve higher than the minimum standard that you continue to speak about.

We will get there as well with two other important points in mind. The first is that we're trying to reconnect community with long-term-care homes. We've all been in those homes that are great. The Chair's probably been in more long-term-care homes than any of us, given his former role. I've gone on unannounced visits, and I've had the opportunity to see lots of terrific care and some that seemed a little bit less so. But we're moving forward in a way which is designed with significant action in four or five different areas to create a comprehensiveness to the nature of the reform that's going to give us a chance at changing the culture. I think that ONA, by evidence by their release on May 11, saw the evidence of a government now in office who had the opportunity and moved on it.

I'm very, very proud of the reforms that we've made and continue to make in reshaping the culture of long-term care in the province.

Ms Martel: Do you think that ONA is now calling for a minimum standard of care as a result of their release on May 11?

Hon Mr Smitherman: What I know from ONA is that they're able to conduct a discussion on more than one point.

The Chair: Thank you very much, Ms Martel. Mr McNeely?

Mr Phil McNeely (Ottawa-Orléans): I know the government's moving ahead with dealing with the doctor shortage and moving our health care system toward primary health care. As part of the budget announcement, there are 150 family health teams coming forward. Can you give us the status of those health teams?

Hon Mr Smitherman: Yes, I'm very pleased to. Yesterday, I had the opportunity to meet with our health results team. This is the seven members of our trans-

formation team that are helping to fuel, to propel forward some of the initiatives that we think are essential to creating a health care system which is working better for patients, to put it bluntly. Family health teams are an essential element of that. Family health teams are something that we ran on in the election that are informed by what we've seen working well at the grassroots community level in a bunch of places in Ontario, when you can bring a team of health care professionals—a doctor, a nurse, a nurse practitioner, a pharmacist—working together as a team with the same group of patients in mind. Family health teams—we're going to roll out 150 of them. The first 45 will be announced this year.

Dr Jim McLean, who himself is a family doctor and the CEO of Markham Stouffville Hospital, is leading this initiative on our part. He's assisted by Dr Ruth Wilson from Kingston. We fully expect that we'll have good-quality uptake, and that communities across the province of Ontario will begin to be the beneficiary of family health teams late in 2004-05 and moving forward with 150 of these over the course of our mandate.

Mr McNeely: Much of the primary care will be delivered by nurse practitioners. To grow a doctor, it takes 10 years; a nurse practitioner, maybe five years. Is that going to be one of the directions we go in?

Hon Mr Smitherman: I think it's part of it, but I think it's also about making sure that, in health care, everybody is operating to the fullest extent of their training. That's often referred to as "scope of practice," and it's a pretty challenging thing.

Family health teams are operating on a simple premise that if the alignment is such that a doctor is working in solo practice independently and a mom has a baby to take back for weighing, the doctor's going to be the one doing that. I think we all recognize that there are a broad array of tasks that a doctor might perform that could as easily be performed by other health care professionals. I think it's important to make sure that we're lining up a team practice to be able to do that.

0950

In terms of our capacity to produce nurse practitioners, one of the incredible experiences I've had as a Minister of Health is to travel to pretty vast parts of the province and really get a flavour of the diversity of deployment of nurse practitioners. So we continue to be in favour, and that's why we're enhancing our capacity to produce them. But I think the real message there that I want to continue to deliver is that it's really about a team and making sure that the most appropriate member of the team is the person deployed.

Let me just give you one more little piece of flavour. Imagine, as an example, that a group of health professionals came together and they were serving a population health base of people who were predominantly seniors. I think it would make a lot of sense to have a pharmacist working in that environment to assist people because of the challenges related to medication.

If a group came together and was practising for a population health base that was in, for example, the member from Pickering's riding—I'm sorry I didn't get the whole name of the riding there; the Pickering part is important because it's a community with lots of young families—it might be appropriate then to have resources that are aligned to assist people in dealing with the challenges related to kids.

This is the kind of flexibility we're going to see in family health teams. They're not going to be Queen's-Park-imposed. They're not going to be overly prescriptive. Communities are going to help to develop them.

Mr McNeely: In Orléans, we're 100,000 people in the community. Some staff have done an investigation, and there are no doctors taking new patients. I've discussed that situation with doctors in a privately run clinic. They run a good show, probably 10 doctors, 10 years—a great record. They're trying to go 7/24, which is a real need for the community and would help. They can't find the doctors. Is there a way that they can interact with your ministry to look at whether they can come up with the 7/24 by using the team approach? Is that something they can do?

Hon Mr Smitherman: I don't know enough about it exactly, but if they're currently operating, if they've already come together, there's going to be a strong chance that they can evolve a little bit further down the primary health care track toward this kind of practice.

Let me say a couple of words on doctor shortages. It's a tough challenge for communities, and you can't help but be in this position for very long before you hear some heart-wrenching stories. We're prepared to be measured on the basis of more access to family docs. The fact of the matter is that this issue is the legacy of those two parties when they were in government.

The member for Nickel Belt's party had a philosophy in the early 1990s which was, if you don't mint new doctors, you don't have to give them an OHIP billing number, and that will save us money. So they choked off the supply of doctors by closing medical schools, effectively. They weren't the only ones who followed that practice. Because the production line for doctors is such a long one, it creates a real hardship. The previous government did increase medical school spots but they waited for several years after they were a government. So those two things really create challenges.

I think the hopeful news is that, first off, since we became a government, we've dramatically enhanced the capacity to get foreign-trained doctors into service faster. When we came into office less than a year ago, IMG-Ontario had the capacity to give residency spots, the last training piece, to 90 foreign-trained professionals. We've got 167 in residency right now, and in December, 550 students will sit for an exam and 200 residency spots will be allocated from that. So on the IMG front there's more progress to be made. Sure, we all know people in communities who are ready to provide that kind of help, and we've enhanced our capacity. We have more to do on that, but we've made good progress.

Secondly, the Northern Ontario School of Medicine—something the previous government did initiate; we were

strong advocates and I think all parties probably were advocating for it for the north—is coming on-line, and in September 2005 the first class of 56 students will sit.

The other point is, with respect to family practice, which is at the heart of your question, I think I said yesterday that when we went into the negotiations with the Ontario Medical Association, the first priority for both sides—and this is the language I've had approved with the two presidents I've dealt with—is to enhance the viability of the family practitioner, to send the strongest possible message that we want doctors practising again in communities, because we believe the best health care is the health care you find as close to home as possible. We've really worked hard to try and send those messages. I've gone to the campuses of medical schools and sent the message that we think family practice is where it's at, and our family health team model is a very appealing practice model for a lot of the docs who are up and coming.

Mr McNeely: That's one of the issues, of course: Family doctors are retiring. I've had two retire in their 50s because they have a better option. I'm presently waiting to get a doctor to take me. When do you think we will see improvement in the ability of someone to get a family doctor, the ability of someone to get treatment, rather than going to emergency at the hospital? When do you see changes starting to occur? These are very slow-moving; they have to be slow-moving when you wait so long for a doctor.

Hon Mr Smitherman: For me the measurement index in health care, facing the realities that we're facing, is that if you track the underserviced communities on a graph, they've just grown and grown. The first challenge, of course, is to stem that tide and then to reverse it. My impression about this is that what we need to adopt for health care is the theme I've tried to adopt for myself personally, recognizing that I have a long distance to travel to be the healthiest person I can be, and that's continuous improvement. I think this is what we're going to be able to demonstrate.

The challenge, of course, is that if you're in an Ontario community today and you're struggling with access, that's a significant hardship, but the combination of things we're doing—enhancing the viability of family practice; introducing care models like family health teams that are really going to give a boost, because it's a whole interdisciplinary team of people—is going to have the effect of maximizing benefits.

We're making investments that are designed to keep people healthier in the first place, vaccinations and the like, and really promoting a healthier agenda, with active campaigns against tobacco and addressing things like obesity. One of the most significant improvements we can make is to help people to have a better understanding of the things they can take personal responsibility for to address their underlying health status.

That's a really long answer—not that that's the first long answer. I sometimes go to events and the answers I give to the questions they ask are longer than the speech I give.

I think Ontario communities will begin to see for the first time in a long time signs of progress, but because we are really starting from such a significant deficit, with between 800,000 and one million Ontarians reporting not having access to a family doc, we've got our work cut out for us. I think, against that measure of continuous improvement, we're going to be able to demonstrate that things are improving continuously.

Mr McNeely: Just one more question, which relates to the last part of your answer. It's the public health nurses and that budget the municipalities have. We've uploaded some of the costs. I think we've gone to 75% funding from 50% funding, but still the municipalities that are under pressure are cutting those budgets. What can we do to put the municipalities—if they're going to get a higher degree of funding, that they increase their budgets and not lower them. The public health nurses can get a lot of the message out. I've worked with them to get the no-smoking campaign going in schools. It's been very effective. How can we get the municipalities to make sure their budgets increase for that aspect?

Hon Mr Smitherman: I'd say is that I'm not sure if that's a bit more the Ottawa situation, but typically public health budgets in Ontario are not decreasing. They are under a lot of pressure and they've been under upward pressure for quite a long time. So the efforts we've made that are contained in this year's budget are very significant because we've put more money into the system—I think an injection of about $40 million—and in addition to that sent a signal to municipalities that we're going to continue to take back some of the costs they've been bearing for a long time.

1000

We're going to make sure, though, that any investment we make is not used as an opportunity for municipalities to slip back but rather that it's designed to enhance the quality of the programming, because I think we all recognize that if everybody—you know, one of the most common things I get in e-mails and from people on the street is a really strong boost to say we're just not doing enough on prevention. In health care a lot of people have adopted the phrase "putting the resources upstream." I think this is right. We've worked hard as a government to try to push resources to the community, which I think is the equivalent. But the role those public health units and those nurses play—I've had the opportunity to do vaccination clinics and the like with them. They're essential to addressing good population health, and we demonstrate how essential they are by the actions we're taking to restore the quality of public health in Ontario.

Operation Health Protection gets at that in a variety of ways. We've had good bodies of evidence from all the reports that were done related to SARS. What you see from our government is a strong response to, again, one of the crisis points we faced as a government, which was the state of public health in Ontario. I agree with you that those units are important and that the role those public health nurses play is very essential. That's why we support them so much and that's why we brought in new

leadership right at the top, with Dr Basrur as the chief medical officer of health. She's someone who has played that role at a community level, albeit in some large communities, and we're proud to have her leadership on this file.

Mr Tony C. Wong (Markham): Minister, my question is related to funding for mental health services, which has been a problem for a long time in this province. It may be that these needs have been perceived to be not as immediate or not as visible compared with, say, acute and emergency health care and LTC, for instance.

As a former chair of the York regional council health and social services, I have long been aware of the importance of these matters. I want to maybe give you an example, Minister. Take mental health in the workplace. It not only contributes to the well-being and quality of life of our citizens but also impacts on the economic well-being of provincial businesses and employers.

Minister, you came into York region a few months ago and attended the AGM for the York region chapter of the CMHA, the Canadian Mental Health Association, and at that time you promised that you would lend strong support to the mental health aspects.

My question is, what is our government doing to improve programs that deal with mental health in Ontario, and specifically in York region?

Hon Mr Smitherman: I appreciate the question, because this has been a passion of mine. I came to office subscribing to the view that mental health is one of those things that has been allowed to be impacted by stigma we have, our personal discomfort—collective maybe—our societal discomfort at addressing mental health issues. People like Michael Wilson have done so much to help push that out there that sometimes the issues did get short shrift. I don't know what else you can point to to explain away the fact that when we came to office, community-based mental health organizations had not seen a penny of base funding increase since before Bob Rae's hair turned grey—not for 12 years. That's two governments' worth.

So what have we done? We've invested, in this year alone, $65 million to serve an additional 13,650 clients. I think the key point you made is that sometimes maybe the community mental health stuff didn't win out in the funding battle, that the acute sector got it, perhaps. The real point here is that if you don't make the investment with respect to mental health at the community level, the cost is going to be borne by the acute centre. This is one of those very, very clear investments where the purpose of the investment is twofold: Help the patient as close to home as possible, and help them early enough so they don't become an acute care patient. There's plenty of evidence that makes the point that if you can get people help a little bit earlier, chances are, if they're going to have a problem, it won't become an episode that is perhaps the beginning of a path toward frequent reinstitutionalization. This is the pattern that many of us have seen with individuals. But if we have resources at the community level, we can make a big difference.

So this year alone: $65 million. That brings our base budget in 2004-05 to $463 million, and the sector already knows this is going to grow to $583 million by 2007-08. For the first time in a long time in Ontario the community mental health sector—it has its challenges because it's been stretched a long way, but it's feeling a sense of connection to the government and I think there's a level of enthusiasm there that has not been in place for a long time.

I would like to make two quick additional points. The first is that CAMH, the Centre for Addiction and Mental Health, has some challenges around capital expansion, and we've been able to support them with a $16-million grant to help plan and design. The second thing is that our colleague the Minister of Children and Youth Services, who has responsibility for delivering quite a few health programs, also increased health care funding targeted at children by an additional $25 million in 2004-05—overall, I think, evidence of a substantial investment in these services by our government.

Mr Wong: Thank you, Minister. I just wanted to know if there will be new programs or expansion of existing programs with respect to mental health in the workplace.

Hon Mr Smitherman: It's interesting. I had an opportunity a few weeks ago to speak with the mayor of Ottawa. There is a big partnership of public and private entities that have come together to address workplace mental health issues, all around one word: stress. I'm not sure how much more support we're able to offer, but I think it's something we have to acknowledge is there, and if there are opportunities to set up programs to assist people in dealing with their stress, then I can think of a few examples of where that might be helpful.

The Vice-Chair (Mr John O'Toole): Thank you, Minister. We'll carry on more with a little stress here in a minute.

Hon Mr Smitherman: Point of order, Mr Chair: Could I ask for a two- or three-minute break to make a little run to the end of the hall and back?

The Vice-Chair: No problem. The committee stands adjourned for about three minutes.

The committee recessed from 1008 to 1011.

The Vice-Chair: I'll call the meeting back to order. The time will now move to Cam Jackson, the member for Burlington.

Mr Cameron Jackson (Burlington): I would like to ask George Zegarac, who I understand is responsible for community health services, which includes CCACs, to come forward for a couple of questions. Mr Zegarac, I understand you have responsibility for the CCACs.

Mr George Zegarac: I do, yes.

Mr Jackson: And you would be responsible for monitoring their budget activities?

Mr Zegarac: Yes. My area and my director, yes.

Mr Jackson: Is it a requirement in Ontario today that when a CCAC reopens one of their contracts with a service provider, they are to notify the Ministry of Health of those changes?

Mr Zegarac: In terms of reopening an existing contract? I can actually get Vida Vaitonis, who knows the detail, to speak to it.

The Vice-Chair: State your name for the record, please.

Ms Vida Vaitonis: My name is Vida Vaitonis and I'm the director of the community care access centres branch in the Ministry of Health.

Mr Jackson: It's not uncommon for CCACs to mutually agree to reopen contracts in the middle of the term of a three- or four-year contract. Is it a requirement to report those changes and their impact on the budget to your ministry?

Ms Vaitonis: The contracts process is managed by the CCACs through—

Mr Jackson: I understand the process. I helped write it. I'm asking you if they are required to report to you when their contracts change. Yes or no?

Ms Vaitonis: It is not a requirement for them to report to us directly.

Mr Jackson: OK, thank you. You would therefore be aware that when a contract is changed by mutual agreement, it has a huge impact on service delivery because the costs increase in a given fiscal year with a budget that you've allocated them, which means they have to reduce service in order to pay higher wages for the same employees to then service fewer hours for the same money.

Ms Vaitonis: If indeed the contract reopening does result in increased rates, they then would have to manage within their budget and prioritize the clients most in need so that there are no untoward clinical effects for the population they're serving.

Mr Jackson: So therefore it's clear that there is a loss of some service, albeit, as the minister referred to earlier, triaging it. That might mean you're not taking the most acute cases and cutting back, but there is a service reduction in access to patient/client care when a contract is changed rather substantively—I know of 12 or 13 that have been done this way—early in, say, a three-year agreement. So you acknowledge that the government doesn't automatically pass on more dollars; therefore, they have to live with higher costs and therefore less service units?

Ms Vaitonis: It is actually an unusual event. I understand you yourself know of 12 or 13. I'm not aware of the 12 or 13.

Mr Jackson: Ms Vaitonis, you couldn't be aware of them, because we've already established that you don't record that, nor do you audit that, nor do you monitor that.

When those of us in public service get contacted by our local CCAC, many of us find out about that more anecdotally. What I want to establish for the record is that this has a negative effect on service delivery. It has a positive effect on the salaries and the base salaries.

I have a series of additional questions I wish to put on the record, so I will continue with those. The question I have then is, are you going to be monitoring the reopening of contracts that come due during the period of time that was announced yesterday when Ms Caplan will be doing her review? It was implicit that all but six contracts would then be frozen. They're not frozen in terms of price; they are simply "extended"—the word used yesterday in the conference. So are you going to be monitoring the cost implications of those changes in contracts?

Ms Vaitonis: Yes. The context within which you're describing the changes is in the context of additional funding being provided to the CCAC. So they manage the volume increases based on that increase in their funding. So there will not be a need to decrease the volume in that respect.

Mr Jackson: Why is that?

Ms Vaitonis: They will be receiving more additional funding each and every year. There's a four-year strategy at the moment that has been approved, with additional funding over the four years. That includes funding not only for the home care side of the system, but also for the community support side. So there's additional capacity added across the entire home and community care system to make sure we're delivering care to the clients in the right part of the system, which is probably the most—

Mr Jackson: I understand that there will be increased funding. However, we have a patchwork of contracts at variances of as much as $5 an hour between nurses in one part of the province providing home care and nurses in another part of the province providing home care.

The point I'm trying to establish here is that the system that we currently have in this province is that a CCAC would have a contract. It would run for three years, we'll say, on average—some are two, some are four, but the average is three. What happened yesterday is, the government said that those contracts that are in place will not be the subject of another competition or review; those contracts will be frozen or allowed to extend themselves. I'm saying that the practice is that whenever the contract has expired and then must be extended, it costs additional dollars.

So my question is, are you going to provide the adjusted dollars to ensure that the levels of care do not deteriorate, as has been the case when they get their budget approved by you and then they reopen it and say, "You know what? We're going to have to go spend another $250,000 because we've added another $2 to the nurses' settlement in order to keep the employees"?

Hon Mr Smitherman: I understand the point—

Mr Jackson: If it's a brief answer, Minister, fine.

Hon Mr Smitherman: It's a brief answer. I think that there's an important distinction that needs to be made between the issue that you talk about, about a re-opener, where the length of the term hasn't changed. That's not what we're talking about here when we talk about extensions.

Mr Jackson: I made it very clear that it's when they're coming due. "When any contract that would expire during the course of Ms Caplan's review" is what I said. You are not freezing those contracts and saying to the private sector, "You must keep those rates." I asked

that question yesterday. It's very clear that what will happen is that, mutually between the CCAC independently and the service provider, which has not previously been a subject of monitoring, you simply make sure that they have contracts in place and they submit their annual budget.

If there's an area of where I'd like the minister's contribution—and I sense that he is aware of the importance of not leaving this review out there too long, because there are going to be communities where there will be service gaps simply because nurses will get a $3, $4 or $5 raise because the CCAC will negotiate. We're not prepared to flow them additional money to cover those. Minister, are you prepared to flow additional money specifically for those contracts?

Hon Mr Smitherman: For the extension period.

Mr Jackson: For the extension period.

Hon Mr Smitherman: Yes, of course. We want to preserve—a couple of quick messages.

1020

Mr Jackson: Thank you, I get the messages.

Hon Mr Smitherman: We want to make sure—

Mr Jackson: I got a very good answer, Minister. Thank you very much.

Hon Mr Smitherman: —that we preserve patient care above all else.

Mr Jackson: I have further questions. I understand that the agenda for the FPT health ministers' conference in Vancouver has already been submitted to you, Minister. Essentially, it is the tying-up-of-loose-ends meeting from the meetings that occurred between the Premiers and the Prime Minister. My understanding from sources in Ottawa is that there is considerable attention being paid by the federal government to the transfers in terms of long-term care. I'm further led to believe that the federal government has indicated to the ministers that there is a first-payer preference.

Perhaps Ms Vaitonis can confirm for me that Ontario's current position is that our CCAC services are not first-payer preference. In other words, if you're in a car accident, you get your home care out of your automobile plan. If you have private insurance and that provides for your home care, that is your preferred payer, and you then come to the CCAC, to the public health care system, to provide any top-ups you may still require. Is that still currently the position?

Ms Vaitonis: The home care system allows for recoveries through government-funded services. So if an individual, through their insurance—and I'm talking about Workers' Compensation Board insurance, for instance—allows for that, the government is still paying for it. Through the health accord, it simply says that the first minister, the Premier of our province, would not be charging a user fee, in effect.

Mr Jackson: I'm sorry, you've missed the question. A first-payer preference is when a citizen calls up their local CCAC—because they can now call on their own; they don't have to be referred by a doctor any longer in the province—and says—and this happened in my own family—"I need home care. I have a broken arm. I'm badly bruised. I cannot manage my chores of daily living." CCACs are supposed to say, "Well, ma'am, if you were the subject of a car accident, you have your private insurance to cover your home care. We would recommend that you get that, since you've paid for it, and if that's deficient, we will top that up." That's the system as I understand it. Frankly, we're talking hundreds of millions of dollars here of kinds of services where there are third-party payers.

My understanding is that the federal government is going to be encouraging that we shift the paradigm here slightly. Now, I don't expect anyone to comment on where the federal government is coming from; I want to establish for the record if we are still instructing CCACs to ensure that if you have insurance—otherwise this is a huge windfall to the automobile insurance industry in this province.

Hon Mr Smitherman: Briefly, the member is misinterpreting the phrase "first payer" from the federal government perspective. What they're talking about is making sure the program does not have user fees. I understand exactly the matter you're talking about in terms of the insurance issues. That was an issue in the discussion about catastrophic drug programs, but when the federal government uses "first payer" from the standpoint of home care, they're not talking about that; they're talking about having a program which does not have user fees associated with it.

Mr Jackson: Very good. Thank you, Minister. As well, for the record, it's a tribute to Evelyn Shapiro in Manitoba and to the architects of our home care here in Ontario that we're the only two provinces that don't charge a user fee. Also, Ontario is home to one third of Canada's seniors but we are providing two thirds of all the home care in this country. We're the envy of every other Canadian in terms of our model, and I know the minister recognizes that.

Regarding the long-term-care beds, could I simply ask—Mr Zegarac, you're responsible for the long-term-care division as well?

Mr Zegarac: Yes.

Mr Jackson: Thank you. Some of the 20,000 bed allocations from the previous government are just being completed in the last year. Can you confirm for the record how many beds from the 20,000 allocation that were budgeted and essentially paid for—but we're now into the operational year cost—are occurring in the last year?

Mr Zegarac: How many have been delivered in the last year?

Mr Jackson: Yes, out of that 20,000. I'm looking for a specific number.

Mr Zegarac: I'll check with Tim Burns. The number of beds we have in total is about 72,854 in the system. I will endeavour to get you the number for this year.

Mr Jackson: Yes, because as I understand it, there are a couple of contracts that were returned. So if I could leave that with you to determine how much of the long-

term-care facilities budget increase is a result of adding homes to the pool out of the 20,000 and, of the monitored 20,000, exactly how many may not have been let yet, without impugning any motive on that.

The next individual, in the interests of time—

Mr Zegarac: I can answer one of those questions right—

Mr Jackson: Mr Chair, how much time do I have left?

The Vice-Chair: About six minutes.

Mr Jackson: It's a specific number. You can get it back to me at any time this morning. Thank you.

My next question is for Mary Kardos Burton, who is responsible for acute care services, if I could ask her to come forward for a couple of quick questions, please.

The Vice-Chair: If you'd give your name for the record, please.

Ms Mary Kardos Burton: Mary Kardos Burton.

Mr Jackson: Welcome, Ms Burton. My question is with respect to the hospital reviews. I wanted to know to what extent the past two hospital reviews that were undertaken by your ministry—I'll tell you very candidly that the concern is that my hospital in Burlington, the Joseph Brant Memorial Hospital, underwent two rather intensive reviews. They found some savings. Two independent audit teams, both internal to the ministry and external, have confirmed that we're at the point where we can't find any more. What is the status of those reviews? We did not get a report back on the second review. Those hospitals did not get the feedback on that second review. Have they been ostensibly shelved or put aside, or are we still being guided by any of the important information that could be gleaned from those reviews?

Ms Kardos Burton: I think what we should focus on is the review process. First of all, let me just say that I am aware of the Joe Brant situation. They've been in to see me, they've been in to see the minister, they've been in to talk to the regional offices, so we're very aware of the kinds of issues they have. But I think what we need to talk about is the review process that's coming up. I think the minister mentioned it.

Mr Jackson: He spent a considerable amount of time discussing it. So you have set aside the past reviews?

Ms Kardos Burton: All information that we get from any review is important, but it's important as we move forward, and that's the review we'll be on.

Mr Jackson: My board specifically asked the question, are they ever going to get a response to their last—the answer is no, they will not.

Ms Kardos Burton: I believe not.

Mr Jackson: OK. That's fine. The previous government paid for those reviews. I understand—

Ms Kardos Burton: I just want to be clear: There are a number of reviews that go on all the time. Is there a specific one that you're referring to?

Mr Jackson: These are the rather large ones that were done late last summer—a year ago; it was a full year and a half ago, rather. But the ministry never reported back those findings. There were two major ones done in the last three and a half years. So it was the last one that none of the hospitals got feedback on.

I understand from the Globe and Mail that your turnaround teams will be sent in from a list of outstanding leaders in hospital performance and we can learn from that. The minister described them very well. Do you have a list, currently, of those individuals?

Ms Kardos Burton: We have lists in terms of people who have gone into other hospitals. We're looking at chief executive officers. We're also looking at chief financial officers. I personally have had a number of the hospital executives volunteer to provide support to other hospitals that are in trouble.

1030

Mr Jackson: So you currently have a list, or you're preparing a list?

Ms Kardos Burton: We're working on a list.

Mr Jackson: OK, very good. Have you determined what the fee might be?

Ms Kardos Burton: No.

Mr Jackson: OK.

Hon Mr Smitherman: Or if there will be one.

Ms Kardos Burton: That's correct.

Mr Jackson: The ministry in some of its informal meetings has been giving advice to hospitals that have indicated they may be faced with bed closures and so on. One of the issues was a review of certain programs that hospitals are providing. My hospital advises me that in their meeting with the ministry, they raised the question, why do babies need to be born in Burlington? Why can't they be born in Hamilton? Is this the kind of assistance the ministry is going to be providing to hospitals like mine in Burlington and others?

Ms Kardos Burton: Sorry, I was fiddling with the microphone. Could you repeat the question, please?

Mr Jackson: In a recent meeting between the Ministry of Health staff and my hospital, the Joseph Brant Memorial Hospital, one of the suggested questions raised by the ministry to the hospital was, in order to reduce your deficit—in this case it's $9 million—why aren't you having babies born in Hamilton instead of in Burlington? My first question was, is this the type of advice you're going to be giving to hospitals? Secondly, if we take the neonatal program out of Joseph Brant hospital and have our babies born in Hamilton—which I think would be outrageous, but let's say you do that—are you going to take away the program funding for that hospital for the purposes of maintaining our gynaecology program and our maternity program at Joseph Brant hospital for Burlingtonians?

The Vice-Chair: We're going to have to be very quick on this. You're over time.

Hon Mr Smitherman: As I understand it—I call a point of order. I've been allowing the member to call up staff instead of working through me. But I just want to say—

Mr Jackson: That is my right.

Hon Mr Smitherman: OK. Someone had a different interpretation of the standing orders.

In any event, what I do want to say about this is, the message I've been sending to Ontario hospitals—large, small and all over the place—is that every hospital in Ontario is valued and has a bright future but it should not assume that its current state, its status quo, is what its future role will be on any issues. As we get into these reviews, it's absolutely certain that we're going to have opportunities to work and look at consolidation of programs, where that makes sense from a clinical standpoint and from an efficiency standpoint, with respect to obstetrics, because it's a really tough one for communities. I've gone into communities and said, "Your desire to hang on to your obstetrics program is understandable on an emotional level. But in some instances, volumes have dropped to the point where the program isn't viable from a patient safety standpoint." I just wanted to frame whatever other answers on that basis.

The Vice-Chair: Thank you very much, Minister and Mr Jackson. Now it's Ms Martel.

Ms Martel: Thank you, Mr Chair. Minister, we were having such an interesting discussion about ONA that I'm going to return to it. I said just a few short days before the announcement you made on long-term care that ONA had met with Monique Smith and said, as their first immediate action, that the government must reinstate by regulation a minimum staffing formula. They made it very clear that the 2.25 hours of hands-on nursing care would have to be higher, given the levels of complex care now associated with residents in long-term-care facilities.

You referenced their press release of May 11, I suspect, to leave the impression that ONA was completely satisfied with everything the government had done with respect to long-term care. I know that you just neglected—not on purpose, but forgot—to read the rest of the release that did talk about staffing ratios. ONA said two other things in that release. First, "We believe the government's plan may be a good first step in raising the level of care in long-term-care facilities, such as establishing tough new standards for inspections, including enforcement. The real improvements for care will depend on the plan details."

More importantly, the final quote in that same release says, "This is why ONA is ... calling for the establishment of staffing ratios that would guarantee necessary time for assessments and care by RNs, especially since the care needs of residents have increased by over 8% in the last few years."

So I just repeat again ONA's concern, which is the concern of SEIU and CUPE, and say, Minister, that while you've told us you think that through the accountability agreements you will have the tools to enforce new staffing levels, my argument is that those should be supported in a regulatory regime where there is a clear regulation that outlines the minimum standards of care per resident per day so that it can be enforced and so that it will be clear to everyone that some operators will no longer be able to continue to always work to the lowest standard, which they have done, regrettably, because there have not been standards in place.

Hon Mr Smitherman: It seems to me that the challenge in Ontario is that the lowest standard be an appropriate standard for all Ontarians and for the loved ones who are in long-term-care homes.

On the basis of the comprehensive package of reforms we've brought forward, including new regulations and details that hold people accountable through accountability agreements and return-of-funding letters, I believe we have created a situation which meets that test.

I certainly didn't say that ONA was completely there; what I did say was that they had the capacity to deal with an issue on more than just one point.

I think the point here is that the comprehensive reforms that we've brought forward in long-term care are going to have the effect of having higher standards in place in long-term-care facilities, not lower ones. That's the bottom line.

The Registered Nurses Association of Ontario said, "We wholeheartedly applaud Premier McGuinty and Minister Smitherman for their clear commitment to older persons." This is another group that was involved in it.

I'm not suggesting that anybody looked at the package we brought forward and said, on this enormously big long-term-care file—I think that's something that we spend in the billions of dollars on—that people are going to be entirely satisfied that their every point has been ticked off the list at a 10 out of 10. That's not what I said. But measured against what we inherited as a government and the circumstances that we operated in, there has been lots and lots of acknowledgement from far and wide and from many, many individuals, as evidenced in my letter book, of their understanding of the efforts we've made to date to improve the quality of care in our long-term-care homes. I'm proud of it, but I didn't say by any means that there isn't more that can be done or that we should rest on our laurels. That's why we're not. That's why I've said we have more work to do. Of course, we have to get those regulations gazetted. We have to get those in place.

We have a piece of legislation that will also be an important opportunity to underline in legislation the principles we have with respect to the operation of long-term-care homes. That piece of legislation will be an opportunity for us to embody the very principles we've moved forward on.

What are those? To repeat: dramatically enhanced inspection and enforcement capacities; clear regulations; enhanced funding—2,000 new people—that's tied to actual patient needs; and family and resident councils.

A really, really clear and demonstrated improvement has been made with respect to long-term care in the last 10 or 11 months. There is lots and lots of evidence around that, evidence which is well-presented in the fact that the associations that are involved in helping to work with the 588—I think that's the current number of long-term-care homes in the province—those associations have worked with us very, very hard over the course of the summer to create a funding package which is directly tied to the results we desire. The results we desire are making sure that every Ontario long-term-care home

meets an appropriate standard for Ontario and that the minimum standard is an adequate Ontario standard. On the basis of the package of reforms we've brought forward, I believe we will achieve that.

More to the point, in those instances where we fall short or where a local operator falls short, we have put in place such an intensive enforcement and inspection capacity that I am very, very certain that the long-term-care sector understands one thing much more clearly than they did before our government came to office, and that is that if you're a poor-quality long-term-care operator in the province of Ontario, we will be on you.

The Chair: Ms Martel, I'm sorry to interrupt. We're having a few small technical difficulties. Without taking away any of your time, we need to take one minute to make some adjustments to the mikes so that we get all of the minister's comments. I beg your indulgence.

The committee recessed from 1039 to 1043.

The Chair: Ms Martel, you have the floor back.

Ms Martel: I just want to make this final point. Minister, the fact of the matter is, there have been a lot of announcements and a lot of rhetoric about change in long-term care, but if you look at what has happened, the money that you announced on May 11, five months later, still is not out the door. On May 11, you announced there were going to be reg changes with respect to bathing, with respect to nurses. Those regulation changes haven't been made, although they could have been made any Wednesday morning at a cabinet meeting, and they won't be made for at least another six weeks.

You have told this committee today that despite promises made by your colleagues and your government last year, before the election, there won't be a minimum standard with respect to hours of care per resident per day. The promised Web site that was going to be up four months after you made your announcement on May 11, giving a profile of each home in the province, is still not up.

The list goes on and on. Lots has been said about what you intend to do and not a lot of action to date in terms of real change in homes. Most homes have not seen any change in staffing. I know because I was at Extendicare/Falconbridge last week—absolutely no change in staffing levels in that home.

We just got an e-mail again yesterday: "I live in a home for the aged at Cummer Lodge, one of 10 owned by the city of Toronto. Dalton McGuinty gave $191 million for seniors living in homes for the aged" and nursing homes "to hire more nurses and care workers. To this date no new nurses or care workers have been hired at Cummer Lodge. I'm Cummer Lodge's representative to the Ontario Association of Residents' Councils.... Where has the money gone?" Well, we found out yesterday that it's not out the door.

We're all very hopeful that the legislation will make change. We know it's needed. But the fact of the matter is, since the big announcement on May 11, there hasn't been any money that has gone out the door; no new staff hired; no new regulation changes; we're still waiting for the Web site; and on and on.

One of the other questions I have is, you talked about inspections. Can you tell me, with your surprise inspections, how many orders have been laid under this new process?

Hon Mr Smitherman: I will get you that information. I want to say—

Ms Martel: And how many charges?

Hon Mr Smitherman: I want to say, the fact of the matter is—

Ms Martel: No, Minister, excuse me. How many orders and how many charges?

The Chair: Minister, let her finish clarifying. You have a tremendous number of staff here. They're taking notes diligently as each question—

Interjection.

The Chair: Please, Minister.

Ms Martel: Is there someone from the staff here who can come up and tell us how many orders have been made against long-term-care facilities as a result of this new process of unannounced visits? Anybody?

Hon Mr Smitherman: We don't have the information.

The Chair: Shelley, are you finished with your questions?

Ms Martel: No, because my second question is, following from the orders, then, I would like to know how many charges have been laid against any nursing home, home for the aged or long-term-care facility as a result of the new inspection process. I would like that information as well, Mr Chair. Do we have that here?

Hon Mr Smitherman: In answer to the honourable member's question, I think it is a—I understand the essential point she's making, but the effort she goes to to demean the work of people all across the sector in the last 10 months is really disheartening to me. The fact of the matter is that we came to office in—I know that you don't operate in a world where you have to remember your days in office, and the rest of us are trying to forget too, but the fact of the matter is that on this file, we have made such significant progress, and for you to characterize all that action simply as rhetoric is, I think, a little beneath the work of all the people in the long-term-care sector.

Ms Martel: Don't be so arrogant, George. Just answer the question. Where's the money?

Hon Mr Smitherman: I answered your question yesterday, but I'll give you the answer again. The money is available to long-term-care facilities as of October 1. They know that, because we've worked with them over the course of the summer to make sure that the money we were investing for care was going to get to care. There's been a problem in the culture of the Ontario health care system where money sent from the Ministry of Health for a specific purpose often didn't end up in the place that it was intended. Has this taken a bit longer than it should have? Yes. I said yesterday that I take responsibility for that. But it took longer because I was desperate to make sure that it got spent in the appropriate place. At the end of the day, I'm very, very proud that we've taken those steps.

With respect to inspection and enforcement, we're going to get you the information you've requested. But for you to suggest that there's been nothing except rhetoric on this front, I think, stands in sharp contrast to reality, which in this case is that inspections have gone—in the period of January to August 2003, there were 1,429. In the same period in 2004, on our watch, there were 2,307. Complaint investigations: In the period in 2003, there were 454. In the period in 2004, there were 880, a 93% increase.

My point here is that this is a big file, and that in the course of 10 or 11 months, we've gone from a point where we've gone out, done a comprehensive report, had the report back, responded as a government and aligned ourselves as a government behind the commitments we've made. For the member to characterize all of that action as rhetoric, when anyone that's up close and personal with the sector, that's involved in resident and family councils and the like, knows that significant improvement has occurred and that there's an evolving and changing culture.

Ms Martel: Minister, if I might, this is what I said. I said, with the exception of the inspection process that you announced, the rest of the announcements on May 11 had not come to fruition. With all due respect, telling us that the money is owed to facilities as of October 1 is a different matter from when they get the cheques in hand.

Hon Mr Smitherman: No, of course it's not.

Ms Martel: Yes, it is. If they don't have the money in their hand right now, how can they go ahead and hire staff? Come on, Minister.

Hon Mr Smitherman: Of course they budget and cash flow. For the member, who served as a minister in a government, to think that an organization doesn't change its operation on the understanding of what money it will have is not appropriate.

Ms Martel: How do they pay the new staff if the money's not there, Minister?

Hon Mr Smitherman: Obviously, they're big operations, and they cash flow just as anyone does that's operating any of these kinds of facilities.

The point is that these homes, both the private and not-for-profit ones, we worked with them diligently all throughout the summer on the development of a strategy that was designed to ensure that the absolute principle, that a dollar sent for care was spent on care, has been confirmed. It did take us a while. I acknowledge it. I acknowledged it yesterday and I acknowledge it today. But I want to say that it's backed up by a very firm and sensible principle, which is that I don't want to be the Minister of Health to face up to, as too many other ministers of health have had to do, a reality where money was sent and wasn't spent for the purpose intended. This is money that's for the front line, not for the bottom line, and we've taken extraordinary action over the course of the summer, through the funding letters and through the accountability agreements, to make sure that the money gets spent exactly in the area that it was intended, which is to enhance patient care.

Ms Martel: The suggestion that I made yesterday is one that I hope you will follow up on, that if you have set targets for each of the long-term-care facilities, then those staffing targets should also be part of what's posted on this Web site, so everybody can see whether or not those facilities are actually living up to the obligations that you have placed on them. I hope that you will do that.

1050

Hon Mr Smitherman: I appreciated the suggestion very much.

Ms Martel: Do you have a response on orders, or is that something different?

Hon Mr Smitherman: We're going to have to dig it up.

Ms Martel: OK. Let me ask another question with respect to long-term-care facilities. You also said in the election document that you would cancel the Harris-Eves 15% increase in nursing home fees. When will that happen?

Hon Mr Smitherman: What we've done this year, again, in the face of the fiscal circumstances we're in, is not raise fees against inflation. Of course, that's a beginning point in terms of assisting people in long-term-care facilities. So that's the first step we've been able to make there. In addition, I think you might know that we've recently increased the comfort allowance to make sure that those most vulnerable or the lowest-income people living in long-term-care facilities have the advantage of just a little bit more money to spend on a Christmas gift for a grandchild or what have you.

Ms Martel: But that's not my question.

Hon Mr Smitherman: Well, the question was clear and so too was the answer.

Ms Martel: No.

Hon Mr Smitherman: The first piece of this has been—

The Chair: Excuse me, Minister. I don't know if anybody knows the answer to that. I think the question was, did the 15% get rolled back?

Hon Mr Smitherman: Not to date, Mr Chair, but I said that the first piece of it has been acknowledged in the sense that, against the inflation of this year, we did not increase payments.

The Chair: Based on the inflation, in what year will you catch up to that commitment?

Hon Mr Smitherman: Well, I'm a bit curious about the role of the Chair asking questions.

The Chair: It's a point of clarification.

Hon Mr Smitherman: The strategy that we're developing with respect to this is going to emerge, but as a government facing the $6-billion deficit that your party left behind, Mr Chair, we've acted in an appropriate fashion, measured against the availability of resources.

What I'm pleased to say is, at the very same time that we put 406 million new dollars into long-term care—some of it targeted at new homes and some of it targeted at the quality of care in existing homes—at the same time that we've been able to increase the comfort allowance,

at the very same time that we've enhanced our inspection and enforcement capacities and moved forward with a series of other reforms, we've also been able to hold the line on costs for people living in long-term-care facilities. I think that, set against the pressures of inflation, this is progress on the commitment that was made.

Ms Martel: Can I ask when, Minister? What's the specific time frame for you to meet your election promise? I mean, I could point out that your own finance critic, Mr Phillips, was well aware of a $5-billion deficit. He talked about it openly in the estimates for the Ministry of Finance in June before the election, and he's on record in Hansard as saying very clearly that the former government had a $5-billion deficit. That didn't stop your government from going out and making promises like this one. So I'd be interested in what the time frame is for you to meet this election promise, which clearly was to cancel the Harris-Eves 15% increase in nursing home fees. What's the time frame for you to do that?

Hon Mr Smitherman: That was the point of clarification that the Chair asked about, and I already have that answer on record.

Ms Martel: No, I'm asking for a time frame. I heard you have a strategy. I wonder what that strategy entails. Is it in two months? Is it next year? Is it 18 months? What is the strategy? What is the timeline?

Hon Mr Smitherman: I think that the timeline is yet to emerge. We have more work to do on this, but I think a key point here that needs to be taken into consideration is that at the time that policies were developed related to this and printed in platforms, there was an expectation that a 15% increase that had been announced by the previous government would be administered, and it wasn't administered subsequently.

Ms Martel: It was the first year.

Hon Mr Smitherman: I'd like to call Tim Burns forward. He could talk to that point a little bit more.

Mr Tim Burns: I'm Tim Burns. I'm director of the long-term-care homes branch.

The increase was announced by the previous government in 2002, to be originally announced at $7.02 per resident day, and it was later implemented at $3.02, which is 9% or thereabouts. The following year, in 2003, there was a $1.16 resident co-payment increase implemented, which was consistent with the rate of inflation.

Ms Martel: Right, and the first year was not consistent. It was well above the rate of inflation. It was well above what would have been permitted in the private rental market if guidelines had been applied to residences. So the first year, there was an increase that was well above the rate of inflation, which the government should be dealing with. If the Liberals put 15% and didn't mean that, that's one thing; I'm sure they meant the increases that did go into effect that were above the rate of inflation, and that first-year increase certainly was. So when will the rollback be of that very significant first-year rate of increase that was well above the rate of inflation?

Hon Mr Smitherman: As I said earlier, the rollback has already begun, and it began this year with not having an increase at the rate of inflation. You know that in—

Ms Martel: But there's a difference between not having an increase this fiscal year at the rate of inflation and dealing with a rollback of a previous rate increase that was much higher than the rate of inflation.

Hon Mr Smitherman: I'm not sure why it doesn't seem sensible to the member that not raising a price when inflation clearly was in occurrence and when that had been the norm doesn't count as some credit toward a rollback. Of course, if the marketplace, in this case long-term-care homes, was conditioned for an annualized increase, even if it was at the rate of inflation, and in a given year there was no increase on the rate of inflation, people would say, "Hey, that's a cost increase that I didn't incur and therefore is the equivalent of a rollback." It's growth in cost that would have been fully expected and didn't occur. I think it seems very sensible that that's a step toward keeping prices in a range that is more affordable for residents, which was of course the goal at the heart of the commitment we made.

Ms Martel: The base rate is already inflated, because in a single year the increase was much higher than the rate of inflation. So any additional increases, even at the rate of inflation, are on an inflated base. That's why residents are out—

Hon Mr Smitherman: I understand. What I would say is that there was no increase this year.

Ms Martel: So you're saying the increase was matched at the rate of inflation?

Hon Mr Smitherman: That was in 2003. There was no increase this year. What I'm saying to you is, faced with, in a sense, the opportunity, the culture of an increase even at inflation, we did not increase the rates at all in 2004. What I'm saying is that that amount is obviously a beginning point to easing the price challenge that people are facing in long-term care. In context, set against the challenges we are facing, I think it was a very good start.

Ms Martel: What's the difference by which seniors are still out? Even if you didn't raise it this year, that increase in the first year was extremely significant, far beyond the rate of inflation. What's the difference that seniors are still out, in either percentage terms or monetary terms, if you can give it to me that way?

Mr Burns: The $3.02 increase we talked about for the year 2002 was $2 ahead of inflation. I would have to get what the increase would have been had we implemented the increase this year. So some of the $2 would still be ahead of inflation. I don't have that number in front of me.

Ms Martel: Can you get that for us?

Mr Burns: Yes.

Ms Martel: That would be great. Let me ask another question about capital this time, that also—

The Chair: Last question, briefly.

Ms Martel: OK—affected long-term-care facilities. In the budget it was stated there would be 12,000 bed lifts

purchased for hospitals and long-term-care facilities at a cost of $31 million. My question is, has this money been spent, how much of that was allocated to long-term-care facilities and what did it buy in long-term-care facilities? Has the money actually gone out the door so that the equipment purchases could be made, and what was the overall result of that? Can you get that back to us?

Hon Mr Smitherman: John McKinley can come forward. He'll give you an answer that I think is the same as mine, which is that we did have a program last year that I had the chance to speak about and we have a program that is yet to roll out in 2004-05, and long-term care is definitely going to be an element of it.

Ms Martel: I thought the budget was $31 million for this fiscal year 2004-05, but you've just said that there isn't a program for 2004-05.

Hon Mr Smitherman: No, no, that's not what I said.

Ms Martel: Then tell me again.

Hon Mr Smitherman: I said we haven't yet rolled it out in 2004-05 but we still intend to.

Ms Martel: So the money hasn't gone out?

Hon Mr Smitherman: That's right. Not only has the money not gone out, but sending the money out is the easy part in this instance, although challenging from time to time. We're working to make sure that we're allocating bed lifts in a fashion that makes the most sense in terms of our broader health priorities, so we're going to be looking to allocate those this year, both in acute care settings and also in long-term-care settings. But this is something we're very proud of from last year, and that's why we went and fought for additional resources, because last year we spent $14 million on bed lifts. I've had the chance to anecdotally speak with a lot of nurses who had been the beneficiaries of that. So we're very committed to doing this. It's an essential element of our nursing strategy.

1100

The Chair: I'll now move to Mr Milloy.

Mr John Milloy (Kitchener Centre): I have a couple of questions on different subjects related to health care but I wanted to start with hospital funding. As you know, I have two hospitals in my riding. I think I have better than the normal layperson's understanding of hospital funding but nowhere near the expertise that I should have. One of the things I'm curious about is that you've mentioned, and I've heard you on a couple of occasions talking about, this $721 million in hospital deficits and that it was rolled into the working capital deficits. I'm wondering if you can provide a fuller explanation as to what that's all about. Also, obviously that's a challenge for you in terms of moving forward.

Hon Mr Smitherman: It's a challenge for all of us, so let me trace you back to the earliest days after our party arrived in government and I was given the honour of this job. I got some analysis about the financial circumstances of Ontario hospitals. As you know, the Provincial Auditor came in and did a two-week review of the government's books. But one thing they didn't capture was that for a period of two fiscal years—I'm pretty sure it was 2000-01 and 2001-02—the government of Ontario and the Minister of Health were working on a kind of nudge-and-wink basis with Ontario hospitals whereby they were encouraged to bury operating costs in their books so that the government could balance its books. They were given the nudge and the wink and told that the money would be around later.

It went to the point that the former Minister of Health called in bankers, representatives of the various banks, to the minister's boardroom and said, "Don't call these notes," because in a certain sense they were unsecured amounts, quite large in some cases.

We have teaching hospitals, some of the biggest hospitals in Ontario, with amounts of around $100 million of what largely amount to unpaid working—in some instances, reports to liabilities from unpaid operating bills from past years. We've analyzed the books and found that $721 million is made up of unpaid operating bills, and we're going to work with Ontario hospitals to take those costs into the books of the government of Ontario. This is just further evidence of what we were facing in terms of the fiscal challenges related to Ontario's hospitals. The fiscal relationships were quite unhealthy and proving pretty problematic from the government's fiscal management capacity.

Mr Milloy: I don't want to belabour it, but how exactly do you bury it? I'm just curious. You talk about working capital. Again, I think I have somewhat of an understanding of hospital funding but not an expertise.

Hon Mr Smitherman: Working capital is a line in a hospital budget that is more typically used to pick up some of the things like perhaps liabilities related to pensions. It's a line that by its description sort of picks up a few things. In a certain sense, they were just encouraged to grow those numbers because the government, it seems, didn't want to pay out those amounts because it would have pushed the government's books into a deficit situation and then cabinet ministers would have had to take a pay cut.

This is the scenario that was underway and one of the things we encountered. In our relationship with hospitals we said, "Obviously, if it's our expectation that we're going to get you back to a healthier fiscal operating viewpoint, then this is something we're going to have to address," and that's something we expect to deal with in 2005-06. In a certain sense, the accounting rules of the day allowed that to occur, but the modernization of accounting rules, if that's an appropriate word, is going to make that kind of practice much less possible in the future, thank goodness.

Mr Milloy: I'm going to switch gears to another issue, one that's near and dear to the people in my riding. In knocking on doors during the election and subsequent to that, I certainly found the biggest issue has been doctor shortages; we're highly underserviced. It's amazing, the number of people who raise with me the issue of foreign-trained doctors. We have in our area an association of qualified doctors, which totals about 80. There are 15 who meet regularly at the multicultural centre, which

opens its doors once a week for a study group. In fact, a local book company, Words Worth Books, has donated texts to this group so that they can perform their studying.

In answering Mr Wong's question earlier, you talked a little bit about increasing the number of spots, but also yesterday, you talked about a new system, or a more streamlined assessment system. So I guess the first question is, what have we done and where are we headed on that?

Hon Mr Smitherman: One of the phrases that I use a lot in health care is "hodgepodge." We use the word "system" a lot. Whenever I say "health care system," a little asterisk goes off in my head, because as I travel around, what I recognize is that some of the stuff that we had out there wasn't well organized, and some of what we've done in some parts of the province hasn't been done in others. It doesn't look much like a system.

The issue around foreign-trained doctors, what we've come to know as international medical graduates, is one such example of, frankly, a real lack of coordination. So we brought the various bodies and functions in-house, in one place. We start with the principle of one-stop shopping. We create this thing called IMG-Ontario, International Medical Graduates - Ontario. Some people call it the clearing house. It's down at Bay and Dundas—I should say at Gerrard and Bay; I should know my own riding well enough—and it's become a place where people can get all the information they need. But way more important than that, it's become a place that is operating on a more streamlined basis.

If we look at the four or five different doctors with different qualifications and different desires to practise in different areas, there are lots of questions, lots of different categories that people fall into. But the bottom line is that we've been able to streamline the process and significantly enhance the number of spots that we have available so that those doctors who write a test and are deemed appropriate to just do some residency and then go off and actually practise—the problem isn't at the assessment level, it's in the number of residency spots that you have. We've gone from 90 to 200. We've filled 165 currently. Next year we're going to hit 200, absolutely.

This year, for the very first time, as evidence of the progress that's being made on this, the College of Physicians and Surgeons said—they put out a release last Thursday—that for the very first time, in the current fiscal year, or the one just past, I think, more licences were given to IMGs, international medical graduates, than to the graduates of Ontario medical schools.

This is a significant piece of evidence that says that even though we have more progress to make and more opportunity to take advantage of in the form of good-quality people—and we all have people like this in our ridings, I think—we've made a significant amount of progress. We're doing a better job than we have before of taking advantage of the skill sets of our foreign-trained professionals.

Mr Milloy: So do you see the government going beyond the 200 level?

Hon Mr Smitherman: I think the one opportunity point that needs to be examined here is about resources, in part measure, and I do think that this is also an area where Ontario could be looked on to play a leadership role, potentially even in assisting other provinces on the training side.

So the short answer is yes. The longer answer is that it would require more resources. People say, "What does it take?" If you're going to ask a doctor to assist a resident, there's a certain amount of mentoring, tutoring and oversight that is associated with that. You've got to pay for that, because you're taking that capacity out of the system.

The federal government, I believe, has got a pot of dough that might be of more assistance to us in broadening even further our residency capacities and giving us more drive-through to be able to get more of these foreign-trained docs practising in the province of Ontario, to build on the progress that we've made.

Mr Milloy: Has there been thought given to foreign-trained medical professionals who aren't going to make it through the whole process but who may want to contribute, not as full-fledged doctors, but who can contribute?

Hon Mr Smitherman: This is a brilliant question. I think it stems from just practical awareness of dealing with people.

I had a guy who worked for me. He was a doctor from Nigeria who had been trained in Russia and had extensive experience providing care in refugee camps, who gave up on the process at a certain point in time because it cost him too much and he needed to take care of his family. He went into a workplace health and safety program at Ryerson.

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One of the things that I've encountered as the Minister of Health is the sheer absence of good strategic health human resources planning. It's an area between my ministry and the Ministry of Training, Colleges and Universities that we need to do a better job around. In so doing, we will have a better capacity—an inventory, if you will—of the assets we have and do a better job of taking advantage of them.

To underscore your point, one example is that as we increase our defence mechanism for public health emergencies around infectious disease and we look to creating more opportunities for infectious disease practitioners, it strikes me that a lot of foreign-trained professionals—particularly because a lot of them bring geographic experience, which means they're quite excellent around the challenges of infectious disease—would be one small example of an area where their deployment would make a lot of sense more broadly in health care. So yes, but more progress is yet to be made.

Between my ministry and that of the Minister of Training, Colleges and Universities, we're developing a health human resources strategy that I think for the first time is going to do a better job of marrying up the needs

of the health care sector with the capacities of our training sector to produce the folks. I think at the heart of this will be a message sent that health care in Ontario in the future, because it's such a significant part of our economy, needs tens of thousands of good-quality workers, and these foreign-trained professionals ought to rank significantly amongst them.

Mr Milloy: And this includes nurses as well. What is the process for nurses to become certified? Is it similar?

Hon Mr Smitherman: It's a similar process. They need to go through the colleges. You will know, I think, that our colleague the Minister of Training, Colleges and Universities has been working very aggressively to make sure there is appropriate protection, if you will, that can ensure that foreign-trained professionals in a wide variety of professions are given appropriate opportunity and can make their way through the regulatory processes various colleges have established. That's something that our government continues to work on and to make progress on.

Mr Milloy: I just wanted to change subjects totally again and talk to you about community supports. It was quite amazing, when I was first elected, the number of organizations that came forward that work with the local home care folks but are separate organizations that do more than just straight medical services. I think they were, quite frankly, blown away by your announcement earlier this year that there was going to be some funding for them. I just wonder, what is the long-term plan on that in terms of these ancillary organizations?

Hon Mr Smitherman: I don't know if you're ever supposed to, in this job, admit to some of the frailties that are out there. Something that I'm a bit more inclined to do is acknowledge some of medicare's frailties. Here's what I encountered as the Minister of Health.

Funds flowing to government for home care, particularly stemming from agreements in Ottawa, had focused home care extensively—almost exclusively—on the challenges of trying to shorten hospital stays. There was this big focus on post-acute care, which is very sensible, because we know that if we can provide appropriate care to people in their home settings, it's much less expensive than in the costly acute care hospital setting. But that decision point came at the expense of serving clients with what I might characterize as more chronic needs, a lot of them just related to aging, where, if somebody had the benefit of a little bit of housekeeping support or someone to do the shopping or assist with some of the cleaning, this might be the crucial link for that individual to the independence they enjoy in their home.

What I saw was that in shifting the focus of home care on to the post-acute care, in a lot of parts of the province the services around the chronic supports—many of those provided by the organizations that you're talking about—had deteriorated quite significantly. I was faced with a policy option that said we're putting $103 million of new money into home care this year and that will buy this much service expansion for clients, while at the same time faced with the prospect that some of those chronic patients would be dropped. I said, "This is not on."

So we scurried within the ministry to get some resources together to preserve those chronic supports and to look for the opportunity to enhance the capacity of organizations—at the risk of offending all the others that are great as well, we were able to put more money into organizations like Meals on Wheels. It's very obvious why that's a sensible investment from the standpoint of a government.

The message I learned is that we devised programs through home care that are very targeted at post-acute, but in so doing, if our focus is completely there, we miss the point or contribute to the very real reality that diminished resources for the chronic supports will lead to institutionalization of a different kind, and that's into long-term-care homes. So we've shored up those services.

You asked me about the longer term. On the longer term I'd say we have more work to do, because there is an obviously growing appetite in all of our communities, particularly from seniors, who wish to have some support to allow them to live as long as they can in their homes. This is a principle that we as a government are strongly in support of, but we're starting from way back. Those programs are pretty frail, as compared to the need.

Mr Wong: Minister, I have a few questions on public health, health promotion and disease prevention. I'll start by asking about our policy and programs to reduce some major known risk factors such as tobacco use. I'm happy to see that there's an increase of about $31 million with respect to the implementation of the tobacco strategy, but I'm also concerned with how we are tackling this increasingly serious battle against substance and alcohol use. What have we been doing or what will we be doing in that regard?

Hon Mr Smitherman: I think consistent with our approach with respect to putting more resources at the community level is the need to support community-based organizations providing services in all areas. To date, in answer to your direct question, we've made more progress in some areas than others, and one of those that will have ancillary benefits for people who are struggling with those challenges is the significant $65-million investment we've made in community-based mental health.

We have significant programs in Ontario to assist people with drug and alcohol dependence. I believe we have 150 separate relationships with addiction treatment programs in the province, but I think that all of us, from personal experience, from the things we see close at hand in our communities, know that this is an area where there continues to be significant need, and more needs to be done to be able to address all of those challenges that are out there.

On the broader question of prevention, I've had the chance—and I'll probably throw some more numbers at you, but you did mention the tobacco strategy particularly. I'm very pleased that we are a government that is going to focus on a comprehensive tobacco strategy. This will restore Ontario to a point in time where—maybe you

have to look back to when Ruth Grier was the Minister of Health—Ontario had such a forward-looking view about trying to really tackle the problem of smoking. I'll just repeat, on that point, that smoking continues to be the number one preventable cause of death in our province. That's 16,000 people lost too soon to our province, to communities and to families. So I'm pleased to see that as a government we've been able to support the priority of working to do all we can to help people, to encourage people not to smoke in the first place and to try to encourage them to quit if they already are.

The Chair: Mr Baird?

Mr Baird: I have some questions with respect to funding for public health and I wonder if I might address them to our chief of public health in Ontario.

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The Chair: Welcome, Dr Basrur. Please state your full name and your position for the record.

Dr Sheela Basrur: Dr Sheela Basrur, chief medical officer of health and assistant deputy minister, public health division.

Mr Baird: Thank you, Doctor. I wanted to talk about the funding between municipalities and the province for public health, the 50-50 split. There's some concern out there that that funding may follow the 45%. So I wanted to ask you, given that we're well into October and that the calendar year for municipalities starts in January, I wonder if you could tell me if we have allocations for the public health file for next year.

Dr Basrur: Having worked at the municipal level for about 15 years, I'm well aware of the challenges that are posed to local public health units when ministry funding comes fairly late in their calendar year, which is their fiscal year. Suffice to say that we are trying our utmost to make sure that our funding letters get out as soon as possible. It is longer than I would have liked it to take, but there are some matters that are still in the decision-making process. As I'm sure the member is aware, I'm not at liberty to speak to all of the details within that except to say that we're committed to getting the money out as soon as possible.

Mr Baird: When might a municipality know?

Dr Basrur: Sorry?

Mr Baird: In Ottawa, for example, where I'm from, when would the city of Ottawa have an expectation of receiving the amount?

Dr Basrur: We are hopeful that it will be within a matter of weeks, not months.

Mr Baird: So that will be the end of October, early November?

Dr Basrur: Hopefully.

Mr Baird: Do you have a commitment that we will follow the 50-50? Is there a commitment that it will be the full 50-50 split?

Dr Basrur: Well, there is certainly a commitment to 50-50 funding in 2004, absolutely. Traditionally the ministry, as you're aware, has approved 50% of the board of health approved budgets. What we are currently engaged in is reviewing the board of health budgets as they have been submitted. Some of those came in fairly late, which is why our end of the process has been late. But we're committed to ensuring that our 50% is covered, for sure. That money will increase in 2005 and beyond, as you're aware. In other words, the current ratio is 50-50. It will go up to 55-45 in January 2005. So in calendar 2005, we will be picking up an additional 5% on that ratio, and then it will increase up to 75% in 2007.

Mr Baird: So municipalities can be confident that that will be coming?

Dr Basrur: Absolutely.

Mr Baird: Thanks. I appreciate that. I have just one more question.

I read with great interest the Liberal campaign platform where they talked about independence for the chief medical officer of health. You have two roles: You're the chief medical officer of health and assistant deputy minister. That kind of looks like the way the previous government operated. How is it different? How do you operate differently from Dr Colin D'Cuhna, being independent?

Hon Mr Smitherman: I'd like to answer this question, and then Dr Basrur could follow, because there is one piece of information I can put in the public domain that she might not be able to. It's simply this: The matter of independence will be the subject of a forthcoming piece of legislation.

Mr Baird: How does it operate differently today than it did, let's say, a year ago under Dr D'Cuhna?

Dr Basrur: I can't really speak to how things operated under Dr D'Cuhna since I wasn't working at the province at that time. What I can tell you is that under Operation Health Protection, which is our blueprint for the future for public health, there is a commitment to codifying and strengthening the independence of the chief medical officer of health through amendments to the Health Protection and Promotion Act, the legislation the minister was just referring to.

If I go back to the plan that was announced publicly in June 2004, 60 days after we had received the interim report from Justice Campbell and when we received the final report from Dr David Walker, who chaired the expert panel on infectious diseases, it was clear that one of the components that needed to be strengthened was the independence of the statutory role that I hold. There were a number of elements that were laid out in that plan relating to the ability and the duty to make reports on matters affecting the health of Ontarians and, secondly, to having a removal of even the perception of political advice or, even worse, interference in public health decision-making. Those elements were set out in that plan of June 2004.

Mr Baird: Do you feel you have that independence today?

Dr Basrur: De facto, yes. It is nice to have it codified for clarity and, as I say, to remove any perception that anything untoward might be the case.

Mr Baird: As the chief medical officer of health, is there a protocol in place on how you're to deal with media calls?

Dr Basrur: A written protocol? Probably in a binder someplace. I would say that I have been given a green light by the minister, the deputy and communications branch, indeed encouragement, to speak out on any matters that affect the health of the public, whether it be tularemia in hamsters, food recalls or what have you.

The Chair: Frozen sushi?

Dr Basrur: Yes.

Mr Baird: I hadn't thought of that one, Chair.

The Chair: Please allow it to leave your mind.

Mr Baird: Last Wednesday your deputy—

Dr Basrur: Associate chief medical officer of health Dr Kurji?

Mr Baird: Yes, sorry; associate—said that he was going to re-review the raw sushi guidelines rather quickly. They had a big consultation process but didn't consult the sushi industry. Was that just completely self-initiated, or was there any suggestion from the deputy or from the minister's office or from the Premier's office that that might be good? I was struck that immediately that it became a media issue your associate just announced a re-review. Was there any pressure or any communication?

Hon Mr Smitherman: I think Dr Basrur can answer the question, but go back to my scrum on Wednesday morning—or perhaps it was Thursday, because I think cabinet was on Thursday. That's my public comment on the record. The public comment was entirely in support of the decision-making apparatus.

Mr Baird: I'm not questioning that. I'm just saying I thought it was rather strange. I just wanted to talk about this independence that you had. You said you've been given a green light. Was there any communication of any sort, any kind, from the deputy, from another assistant deputy minister, from the communications branch, from the Premier's office, from the minister's office, or was this re-review entirely initiated—

Dr Basrur: The message regarding a three-month window while this regulation is in effect to proceed with education as well as further consultation with the industry in order to ensure that everyone understands the rationale for the requirements, what the enforcement—

Mr Baird: I'm talking about the new three-month; not just a three-month. I understand, here in the city of Toronto—in Toronto Centre-Rosedale, that's where I enjoy sushi—they weren't enforcing it for three months. But then it appeared that there would be, from the associate who works under you, another three-month consultation. I just wanted to know.

Dr Basrur: No. I think, with respect, Dr Kurji's comments and what I'm saying now pertain to the same three months. In other words, often when a piece of legislation or regulation is introduced or changed, there is a window of time in which education is the predominant activity, and warnings and enforcement follow thereafter, so that you're not coming down like a ton of bricks as soon as a law is changed.

Mr Baird: But I understand, from the Toronto Star article, that there is a reconsultation, there's another three-month consultation.

Dr Basrur: Perhaps that's a misunderstanding. My view of the matter, just to answer your question, is that it was not on the advice or recommendation or direction from the acting deputy or from the minister or anyone else at a political level.

Mr Baird: So there is another three-month consultation being undertaken?

Dr Basrur: What I'm saying is, (1) if your question is toward this end, I was not pressured by anyone at the political level to back off; and (2)—

Mr Baird: Is there a three-month extension?

Dr Basrur: —there is a three-month window that we are using in part for education and in part for consultation. It is not a second three-month window. That period of time will be used to ensure that everyone understands the scientific rationale, that the rules are practicable—they are practical as well as being science-based—and that if there are any modifications required, everyone understands the reasons for that and we make them at that point, and that everything is straightforward, because there are some mixed opinions out there. Some public health practitioners feel this is well-grounded and that we should stay the course. There are some who feel that it's too much, too soon, perhaps, on a relatively small issue in the food safety scheme of things. So we'd like to gather that opinion and make sure we're proceeding down the right road for the right reasons.

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Mr Baird: Did you get any communication whatsoever from the minister's office or the Premier's office?

The Chair: Mr Baird, I believe the doctor has answered that question fully.

Mr Baird: No, she's felt no pressure.

The Chair: She's confirmed that for the record. I'd ask that you move on.

Mr Baird: Was there any response after the—there was somewhat of a media furor. Did you hear from them?

Dr Basrur: Sorry, your question was?

Mr Baird: Did you hear from the Premier's office, the minister's office, the deputy's office on this issue?

Dr Basrur: Certainly, whenever there is a contentious issue in the media, whether it has to do with a regulation or something in the newspaper or some matter of public concern, there's always a flurry of e-mails and issues notes and so forth that go up and down the system. I'm certain this was treated no differently from any of those other issues.

Mr Baird: Did they offer any opinion?

Dr Basrur: I can't recall, sir.

Mr Baird: OK. Thank you very much. I appreciate that.

Dr Basrur: OK.

Mr Baird: I have another question for the minister. So thank you for your questions, and best of luck in your new responsibilities.

Minister, I have a letter from the Ontario Hospital Association, dated September 20, writing to me as a member of the provincial Legislature to share some

urgent information with me. The OHA states that your funding "falls far short of meeting the real cost of caring for patients. ...hospitals are being forced to make some very difficult decisions on how to proceed." They say that they have provided you, over 10 months, detailed information about the funding pressures they face in 2004-05 and that their pressures are entirely predictable. It goes on and discusses various issues that we've discussed.

They've also included a list of examples of unprotected patient care services. You've given a list of patient care services which must and cannot be touched, but there are some other services here. It's a rather long list. I wanted to raise a few of them with you and find out why you didn't think these services deserved to be protected, among which are emergency—

Hon Mr Smitherman: I'm listening.

Mr Baird: I'm happy to give you a moment to look it over.

Hon Mr Smitherman: You keep talking. The more you talk, the more I'm going to talk.

Mr Baird: Things like emergency room services are unprotected. Things like services with respect to muscular dystrophy are unprotected. Services in the area of neural surgery are unprotected.

I was just in caucus and we were discussing a resolution that's going to be brought forward by the member for Etobicoke Centre on the importance of palliative care. Palliative care beds and palliative care clinics are not protected.

Oncology clinics, support for patients in Ontario with cancer, are not protected. A double whammy for people seeking physiotherapy services: Not only are they being delisted from the paid services provided in Ontario but apparently they're left unprotected as well. Another double hit for people suffering from cancer: Radiology services are not being protected. Spina bifida services are not being protected. Why don't these services merit protection, whereas others do?

Hon Mr Smitherman: I'm going to give John McKinley an opportunity to talk to you about the protected and unprotected status related to programs, which is a long-standing practice and certainly is exactly the same as the practices related to the way your government governed on these points.

A couple of points that I think are helpful to make: We've all seen the letter, of course, because it was sent to all of us. My message in response to it has been pretty consistent and clear, and it is that Ontario hospitals have had report after report after report and then a few more reports as well, about a foot and a half high, I think, if you stack them up, that demonstrate there are significant opportunities whereby hospitals working together can do a better and more efficient and less costly job of managing a variety of their affairs. Some hospitals in the province of Ontario maintain lab services, as an example, when other significant-scale labs are available for them to—

Mr Baird: Privatized labs.

Hon Mr Smitherman: No. With all due respect to your desire to fearmonger—

Mr Baird: This is the OHA, not me.

The Chair: Let him finish.

Hon Mr Smitherman: With all due respect, your suggestion that the lab that is operated by hospitals in the city of Toronto that have come together is some privatized facility is just baiting. The point here is that there is report after report after report that has indicated that there are considerable cost savings available to Ontario hospitals that they have not yet taken advantage of. I send the strongest encouragement to them in all forums possible to let them know this government wants to see progress on those points.

The deficit number that has been around and is quoted in that letter is the same number that's been around for five months. My message to Ontario hospitals, delivered personally on Friday, was that you can't really convince me that on an $11.3-billion base, you can't find a penny of savings to set against that.

This brings us up to current. On October 15, Ontario hospitals are going to begin to send in reports, and Mr McKinley can give you more detail about that. Contained in there are going to be the options that they've considered, that they are considering, to address the budgetary challenges we're all facing in our day-to-day realities. It's the ministry's obligation, on behalf of the government, to determine which of those things that they put on offer are going to be accepted. So the basic message I send to you and to Ontarians is that the issue of protected is made moot by the point that our government will be involved in helping to make those decisions. We've indicated pretty consistently over the course of the last several hours I've been before this committee that it's our full intent and expectation as a government that we're going to work through these matters with Ontario hospitals on a case-by-case basis with a view toward minimizing impact related to patients.

What else have we done? We've really focused, we've really sent the Ontario hospitals into—we've put circles around other things like nursing, as an example, which under your government was the only place that hospitals really ever had to look. When they needed to balance their budgets in the past, what did Ontario hospitals do on your watch? They just laid off nurses. We're going to work through these on a case-by-case basis with hospitals and seek to ensure the least possible disruption to any care that relates to the patient by focusing the effort on saving money in those areas that are non-clinical.

I would like Mr McKinley to give you a history of the protected piece, because it—

Mr Baird: That wasn't my question.

Hon Mr Smitherman: Of course it was, around the issue of protected.

Mr Baird: I want to know why cancer care is not protected.

Hon Mr Smitherman: That's why I think the use of the word, especially as you've advanced it, is erroneous. I've sought to correct that. The second point I could

make is that there are enhanced volumes related to cancer care. Mr McKinley can put some of those descriptions in context in a very helpful way.

Mr Baird: It's from the Ontario Hospital Association.

The Chair: Mr Baird, you have one minute left.

Mr John McKinley: My name is John McKinley. I'm the executive director of business services.

The development of priority programs, as we call them, or protected programs, has been a long-standing practice between the hospitals and the Ministry of Health since the mid-1990s. It has largely grown from very specific programs that were indeed high-cost and had a high impact on a patient's ability to survive.

The program is designed so that individual hospitals are assigned targets in volumes of services. That's why they're considered protected. Those volumes are increasing every year in the majority of the high-cost areas, and we monitor those to make sure that services are provided. We get independent outside advice as to what the volumes should be through groups like the Cardiac Care Network and others, depending on the program.

Mr Baird: Why wouldn't you include oncology and radiology services in that list?

Mr McKinley: As I say, there are different reasons for different priority services.

Mr Baird: What about that one?

Mr McKinley: The challenge with oncology is that it is a very broad program, and understanding the breadth of all of the services that go along with cancer services, including systemic radiation and also the surgery that goes on in hospitals—it is a cancer service, but it is not protected in the same way. The volumes of services that are done through Cancer Care Ontario are part of the protected services as well.

Hon Mr Smitherman: On a point of order, Mr Chair: Can I request a two-minute break? I've been up since 6 o'clock. I've been drinking water since then. I've got to go to the washroom. I'm going to be right back. I'm happy to tack it on the end. I apologize.

The Chair: No, that's fine.

The committee recessed from 1141 to 1144.

The Chair: Ms Martel, you have the floor.

Ms Martel: I have some questions on home care. Minister, the government made an announcement about funding for CCACs on July 5, and I'm wondering, has that money gone to community care access centres?

Hon Mr Smitherman: Yes, but I'm going to get the director.

The Chair: The Chair recognizes Vida Vaitonis has returned.

Ms Vaitonis: Thank you. Yes, the money has flowed to the CCACs.

Ms Martel: Is it the same amount of money that was listed on the July 5 release; that is, the full amount has gone to each of them, in the amount that was listed centre by centre?

Ms Vaitonis: Yes, it has.

Ms Martel: In the budget—I don't know if you can answer this or not; Minister, you might have to—you stated that the enhancements to home care are going to ensure that about 95,000 more Ontarians are going to receive care in their homes. How did you arrive at that figure?

Hon Mr Smitherman: At the same time, we've also put out numbers about the growth in home care, and the 95,000 figure is the projection based on the increase over the period of four years. So the language is "by 2007-08."

Ms Martel: Let me go back. It's based on what we're currently funding now times as much money as you're going to add to that system. Is that how you arrived at the figure?

Hon Mr Smitherman: Yes, but the ministry's going to have to give you some methodology around that, because they were the ones that helped to created the number.

Ms Martel: Can I have that? I'd like to know what the base year is that you're starting from, in terms of making that projection.

Ms Vaitonis: We would be looking at the 2002-03 base as a starting point when we were developing the formula to look at the additional funding, because we've worked over the last year on this particular process. It's a fairly simple formula. You look at the cost of the care, meaning the nursing visit, the homemaking visit, the social work visit, and you identify how many individuals you believe you will need to provide care to and the intensity of care—that means the frequency of their visits over the time frame—and then you look at what that total cost is and project what the full amount will be.

Ms Martel: So your cost of care must be an average, because it would—

Ms Vaitonis: Correct, but you look at the least amount of care to the maximum amount of care, and you average it out.

Ms Martel: Times the number of clients and the intensity? I'm not sure what that's a factor of.

Ms Vaitonis: Intensity means the number of visits over a week, for instance, and the number of visits per day that you would be providing.

Ms Martel: So you're using, essentially, the client numbers—am I correct?—from 2002-03 as the base, the clients served.

Ms Vaitonis: That was the basis on which we started to work on developing the amount of money that would be required, because those were the figures we had at hand for ourselves. We looked, of course, over the past years. You look not just in one year, but you look at the data from years before as well to help you design the program as it's going to unfold in the future.

Ms Martel: I have some questions about regulations. This goes back to some commitments made during the election campaign in the health document, Minister, when you said that a Liberal government "will remove the arbitrary Harris-Eves limits on home care. If you require care and want it in your home, and that care costs less than sending you to a hospital or nursing home, we will make sure you get it."

I'd be interested in what regulation changes have been made in the home care sector to remove some of the limits on care that were put in place by the former government.

Hon Mr Smitherman: I think that we haven't made any regulatory changes on that process yet. But one of the ways that we begin to address this—it's a little bit to the point that I spoke about with members from the government side a little while ago around what's happened over time with chronic care supports being diminished. So in addition to the amount of money that we've put into home care, we've also worked to shore up some of those community supports that are essential to prevent people from moving to institutionalization, along the line of the language that was referenced there.

Ms Martel: I'm thinking of supports that are now offered by CCACs. For example—and this was a case that some of your colleagues, Ms Pupatello, in particular, raised under the Conservatives—one of the regulation changes was essentially to limit home care supports to two hours per day. You'll remember the case of Ms Leatham, out of London, who is a severely disabled special needs child whose care required much more than that, and who had been getting much more care than that from the CCAC. She needs more than two hours a day. As I understand it, that regulation is still on the books, limiting her care and the care of everybody else to two hours per day. That's an important regulation that has to be changed. It's a direct matter of you making that change and telling the CCACs to do something different. When can we expect a regulation change in that regard?

Hon Mr Smitherman: I think that, in part measure, you use an excellent example of the situation for people who have such a severe need. Another instance where we run into the service maximums challenge relates to some of the programming around palliative. We're working this year on the development of a palliative care strategy, and part of the money that's flowed to CCACs is money to assist them in helping us to develop that hospice and palliative care strategy. I think these are areas that will inform our knowledge about regulatory changes that are required to be able make that kind of programming more successful.

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Ms Martel: But, Minister, if might, I don't think I'm referencing—Marlo Leatham's case has really nothing to do with palliative care. She's a special-needs child, like many others in the province, whose parents are trying to keep her at home and who really require additional support. They had that additional support before the Conservatives changed the regulation, limiting the number of hours of care for their children. I didn't ask about palliative care, because I'm interested in a regulation change that would start to respond to special-needs children, for example, who now have their home care limited because of that regulation.

Hon Mr Smitherman: You'll note that as Minister of Health I abide by the rule of not talking about individual cases specifically. In some instances I think it's been a challenge created by the absence of our ability to develop proper personal care plans for people and to give them more control over their own resources in those instances where the nature of the care need is so intense.

The reason I was making the connection with palliative is that palliative is an area of health care services that creates a very similar condition, which is that the need is sometimes greater than the care that is available. So working through those issues this year, as we are, is going to have the decidedly positive impact of helping to better inform our need for regulatory changes that would affect the kind of situation you were raising as well.

Ms Martel: Let me raise a different one that also doesn't include palliative care but was clearly a regulation the Conservatives brought in that was very limiting, and that was regulation 386/99. That essentially said that an individual who did not have a personal care need could not get homemaking services. I don't think that would require personal care plans to any great extent. What it does require is that regulation to be abolished and a new one put in place that says, "You don't have to have a personal care need in order to get homemaking services." There are many constituents in my riding who are well able to look after their personal care needs but certainly could have used homemaking services in order to stay in their homes. That's another example of another regulation that I thought would be changed by now, and I'm wondering when we can expect that change.

Hon Mr Smitherman: I don't have a timetable for the honourable member on that. I'm happy to work toward one and to get back to her.

I'd make this point: I've used this expression a few times already in my appearance and it's an expression that I use a lot. It's an expression that I think reflects the practical realities, which are that across the breadth of a $30-billion ministry you work through your problems, you triage them. My first priority with respect to home care in this province was to get more resources for it. We've done that. The second priority was to begin to work on the processes around provider selection so as to ensure a greater degree of stability for patients and workers alike. We've embarked upon that by asking Ms Caplan to do that body of work. I think this is evidence that we're working through these challenges as relates to home care.

I want to say one thing further. You've raised the issue of homemaking services, and twice in these hearings this morning, the first time under questioning from the government party, I've been able to say that I think this is one of medicare's current frailties. In the movement to make home care so focused on post-acute, we have left behind what I might characterize as some of our more traditional home care services along the lines of homemaking, as you referred to in your last question. I think as a result of that, it's evidence that this is an area where we do have more work to do. I can assure the honourable member that once we've had the opportunity to hear from Ms Caplan and to move on the recommendations she brings forward, we'll take that resource of our time and

energy and turn it to the other improvements that can be made to make sure home care is evolving in a fashion that works better for patients across Ontario, because we see it as an essential link to their independence.

Ms Martel: As I understand it, though, her review is going to take six months. Are you essentially saying we will not expect regulatory changes in home care to abandon some of the very restrictive regulations around care imposed by the Conservatives until at least six months from now, until Ms Caplan deals with the competitive bidding issue?

Hon Mr Smitherman: I think that's a reasonable expectation.

Ms Martel: Can I ask why you can't do those two things at the same time? She is off doing her work, and I appreciate that she is, but these regulatory changes are, frankly, extremely important. They were commitments that were made by your government. I really don't see what is the matter with having her out there doing her review for the next six months and your ministry being seized of at least two regulation changes which would significantly ensure that clients who had their service cut off or severely diminished under the Conservatives actually get some of those services reinstated.

Hon Mr Smitherman: First, in case I left an incorrect impression, let me fix it. I wasn't suggesting that the changes are dependent upon the work of Ms Caplan.

Ms Martel: They can't be. They're different.

Hon Mr Smitherman: Yes, but I never said it. What I did say is that I'm asked and our ministry is asked to work through a series of challenges. You've raised two. You've said, "These things can't be that hard. Why can't you just get on with it?" But that's not the way the world at the Ministry of Health works. There is a capacity to deal with challenges. We have taken on a considerable number of them and we're working through them.

The only point I would remind the honourable member about is that we were elected for a mandate, not just for a minute. The things that we ran on are things that we continue to be motivated by, but we've got to work through the series of these challenges. Look at what we've undertaken in 11 short months: significant renewal of public health, significant work on long-term care, lots of hard work and challenges around doctors' issues, negotiating agreements with the Ontario Medical Association and the like.

My only point is to say that the practical reality of our challenge at the Ministry of Health is not so different than the practical reality that Ontarians face or that you face, and that is, set against 200 things that we might wish to do is the practical capacity to deal with 35 or 45 or 50 of them. We're working our way through those lists in a very fast fashion and making lots of progress. Home care is a file where we have more progress to make.

Ms Martel: The clarification I'm seeking is that essentially what you have said is that until Ms Caplan has finished her work—and I didn't suggest that her work was dependent on regulatory changes—for at least another six months I should not anticipate any changes with respect to regulations in home care. Is that correct?

Hon Mr Smitherman: Yes. I think it's a reasonable expectation. We're working our way through our issues with respect to home care, and regulatory changes that are appropriate will follow.

Ms Martel: Where does the repeal of Bill 130 come in in terms of that time frame?

Hon Mr Smitherman: I think this is the same sort of time frame that's appropriate to deal with. Our priorities have been established: more resources and working to try to enhance the capacity of providers and patients to have stronger continuity of care. Those are the things we're tackling. As we make progress on these, and our energies can be reallocated to other priorities, that's the way we work, because our capacity, our resources—the limitations of time and of the government timetable are very genuine. Accordingly, we have to be very focused and work through the long list of problems and challenges that exist in health care today.

Ms Martel: Just to be clear, I should not expect a repeal of that legislation before six months.

Hon Mr Smitherman: Yes. I think that's a reasonable expectation.

Ms Martel: OK. Let me deal with community supports and supportive housing. I want to raise a question with respect to clarification of what the increase is. My understanding from the press release in July was that you had announced about $29.2 million for supportive housing and community support services. When I look at vote number 1409-1—I assume I'm looking in the right place, and someone is going to help if I'm not—if I look to the two line items of community support services and supportive housing, it reaches a little over $16 million. Can I have some clarification from staff or whoever wants to provide it to me of what the actual vote is in this regard? Because I don't see where the $29.2 million comes in on the line-by-line voting.

Ms Vaitonis: Just so I get your question, you're asking where the full amount of $29.2 million comes from?

Ms Martel: Is coming from, yes.

Ms Vaitonis: There was 14.3 million new dollars added through the budgeting system, and within our current budgeting process, within our current allotment from previous years, we knew that there was funding that had not been spent on community support services. It was actually funding that had been underspent, particularly around initiatives or areas where there was, for instance, not an uptake. I can speak particularly to the Homemakers and Nurses Services Act, which is a cost-sharing program between ourselves and the municipalities. The municipalities are the driver for that particular program and they have not accessed it, although we had to leave monies aside for it. So after looking at a five-year history in the past of the monies being underspent, we decided to use that money to add capacity to the whole system, in particular to the community support service side. That's where those dollars were found.

Ms Martel: Just so I'm clear, of the $29.2 million that was announced, $14.3 million was the actual amount of new dollars.

Ms Vaitonis: Correct.

Ms Martel: And has that money gone out the door to the community support service agencies?

Ms Vaitonis: Yes, it has.

Ms Martel: When did it go out?

Ms Vaitonis: I'd have to check the actual date. We sent letters out in July from the minister himself.

Ms Martel: Letters went out, but I mean the cheque's in the mail.

Ms Vaitonis: Yes. Actually, I believe the monies have flowed but I can confirm that with you after I speak to my staff.

Hon Mr Smitherman: The point is, if you're running an organization in Ontario and you get the funding letter, you're operating on the basis that those resources are in your account. We all know that.

Ms Martel: Except, if I might, Minister, these are community-based agencies that haven't seen an increase in a long time. In fact, many of them have been laying off staff because they haven't seen an increase. So I'm sure a lot of them aren't taking that to the bank, because they don't have the capacity internally to actually hire new staff. I think that's the situation with many of these community-based agencies. Correct?

Hon Mr Smitherman: Yes. No doubt smaller budgets have different challenges, but please at least acknowledge the distinction between an announcement, which of course there's always going to be scepticism around, and the actual receipt as an organization of the funding letter. There is an operational response that occurs in the heart of the board or the executive director that says, "We can now begin to plan around these resources." Yes, of course, cash in the bank is what actually gets it done, but the funding letter is significant. When the funding letter lands on the desk of the board chair, the CEO or the executive director of the organization, this is a significant piece of news.

Ms Martel: Except, Minister, you and I both know that a lot of these community-based agencies don't have the flexibility, all right? When a new employee actually starts and additional services are actually added is when they get the cash in hand, not before. That's the same for this group of agencies as it would be for the community-based agencies delivering mental health as well, because of the pressures they've been under. There is a huge difference between when the announcement is made, when they might get the letter and when they actually might be able to hire a staff person to provide additional resources in the community.

Hon Mr Smitherman: No doubt whatsoever, but let's not forget that most of those funding pressures began when you were in government.

Ms Martel: Minister, I think there was a significant difference between the recession under which we governed and the money that you're getting, both through the new health tax that you've imposed on people and the federal money, which I hope is going to be spent on health care services. I guess we'll wait to see if it really is, won't we, Minister?

The Chair: Thank you, Minister, and Ms Martel. We have come to the conclusion of Ms Martel's 20-minute cycle. This committee stands adjourned until 1 o'clock.

The committee recessed from 1204 to 1305.

The Chair: The standing committee on estimates is reconvened. We're welcoming the Minister of Health and Long-Term Care, the Honourable George Smitherman, and I'd like to recognize Mr Wong in this rotation.

Mr Wong: I will continue with my questions on public health, health promotion and disease prevention. Minister, I'm happy to see that funding is provided to increase capacity for health promotion through information dissemination, consultation, training and networking across the province. My question relates to information dissemination, and this is one you've probably heard before. In York region, about one third of our residents were born outside of Canada, and in my riding of Markham the majority of them do not have English or French as their mother tongue. How are we dealing with the language aspect in that regard, outside of English and French?

Hon Mr Smitherman: I'm going to ask Dr Basrur to come forward to either back me up or contradict me. My instinct is—of course, I'm a resident of the city of Toronto and I see that Toronto makes decisions around how it's going to communicate with its residents. Obviously, in a situation where we have a very diverse province and the information we're communicating is of such an important nature because it's around personal health, the question you raise is a good one. I'm not sure what the practice has been about the dissemination of public health information in languages other than English and French.

Dr Basrur: To build on the minister's comments, there are a number of mandatory programs under the Health Protection and Promotion Act. One of them is known as equal access, which requires all boards of health to either provide or ensure the provision of services with due regard to barriers to access, whether they be language, literacy, geography etc. Clearly, in the GTA, it's evident that language can be a significant barrier to accessing available services if materials are not translated either in written form, video, verbally etc. It's up to each local board of health to make a determination of the barriers that face those residents in understanding and accessing available public health services and to do so accordingly.

The ministry monitors self-assessed compliance with the equal access standard on a periodic basis and collects those statistics. I will say, though, that under operation and health protection, we need to do a review of the capacity of local public health units, which will include an assessment of their ability to properly meet all of the needs of their populations, including with regard to language barriers.

Hon Mr Smitherman: One piece of further information: When the ministry is doing communications, paid advertisement, around specific health-related concerns, we have a standard package of 21 languages that

we use community newspapers for, to assist us in disseminating to that list of communities. The communications branch is going to get us a list and I'll circulate that to the membership of the committee, to show them what our standard package of languages is that we're attempting to get information out to. When we do notification using community newspapers, we do a very broad expanse of languages.

Mr Wong: Thank you for that answer. Minister, you have said it yourself that information in relation to health issues is more important than some of the others, because to our residents it could be a matter of life and death. So I do hope that the ministry will monitor the progress of various municipalities and do a good job in so doing. My understanding is that in York region some of the pieces are either translated or summarized in six languages. Of course, every municipality is different. So I want the ministry to take note of this, that this is something we should do more than just pay lip service to. We've always said that our diversity is an asset, and multilingualism is part of the work we're trying to target.

Hon Mr Smitherman: Point taken.

Mr Wong: My final question relates to the promotion of wellness by changing people's attitudes, opportunities and practices regarding their health. I know you are supportive of TCM, traditional Chinese medicine. What will happen in that regard?

Hon Mr Smitherman: The issue of traditional Chinese medicine is one that we're going to undertake a body of work on very shortly. We think it's important to make sure that we're doing an appropriate job of regulating those professions. We've seen some instances, especially from the province of Quebec, with health concerns around acupuncture, as an example, and that dictates that from a public health point of view, we should act on that. That's a matter on which we expect to be in a position to seek a lot of input from constituents and from members of the Legislature.

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I think it's incredibly important that we should be sending strong signals and messages any time we have the opportunity to be involved in some element of health promotion. We often refer to getting resources upstream or driving them down to the community level. This is entirely consistent with our goals as a government, that we believe the best health care is the health care that you find as close to home as possible. It follows, therefore, that we should be making sure we take advantage of the provision of all of those services for what they can do in terms of promoting healthy and active lifestyles.

Mr Wong: My final question relates to outbreaks of disease, and I'm referring to SARS and the avian flu. I think some of your staff members are aware of the fact that there have been, apparently, some outbreaks in Asia. With the increasing amount of international travel and interaction of globalized businesses, of course, how are we going to be prepared for such outbreaks if they do happen?

Hon Mr Smitherman: I'm going to give a first answer, but I think Dr Basrur, with her obvious expertise, should follow suit.

We've worked hard in the days—obviously, many of the people who are supporting me today are professionals from the Ministry of Health and Long-Term Care, and they are a battle-hardened group as a result of the experiences that they went through collectively in helping to bring SARS to an end in the province of Ontario. The fact is that those experiences and the work of Dr Walker and the expert panel on infectious disease, the work of Justice Campbell and Dr Naylor as well at the federal level, have dramatically informed our sense of what's necessary.

Clearly, there were serious gaps in the communications capacity of the provincial health infrastructure. I had an opportunity yesterday, in answer to the member from Nepean-Carleton, to point out that we're spending, I think, $12.7 million this year on the expansion of the kind of communications infrastructure, the computer infrastructure, to make sure we can adequately tackle these things. We've put together a very, very significant committee of health service providers who have worked to develop pandemic flu plans and the like. So much progress has been made.

We don't rest on these matters, because we've seen Ontario tested. We want to make sure that if Ontario is going to face any future tests, we're better armed, that we learned the lessons from last time. But way more important than that, we're working to make sure that we put in place a system that's designed to prevent infectious disease spread in the first place. That's why another element of expenditure increase that I had the opportunity to discuss with the minister, the member, from Nepean-Carleton yesterday—I just made him very happy; he thinks he just got his car back—was that we will also be working to better inform the public about the very practical things we can do as individuals to protect ourselves against the spread of infectious disease.

I'd just remind people, and maybe it seems too basic, that there was an incredible lesson learned in SARS about the power of the individual, about the extraordinary opportunity for reinforcement about the need to do something as simple and basic as hand-washing. That helps to make the point, which I think is an essential one, that if you want a good health care system, there's an element of personal responsibility and personal opportunity to influence the extent to which we're properly addressing a variety of health care challenges. That's an important lesson that was learned.

I think Dr Basrur could give even more insight.

Dr Basrur: The minister has well summarized the major lessons that were learned from the SARS experience. I would only add that one of the observations arising from the many reports that were done was that the three levels of government were not working in a truly efficient and co-operative fashion as much as the public might have expected during the SARS outbreak, for a whole variety of reasons. I think one of the battle scars

that those of us who survived that experience now bear is that if you don't find ways of co-operating, then the public's health can be at risk.

So I'm really happy to see that the federal government, for example, has created a public health agency, that the provincial government has committed to creation of a public health agency, and that we have a new national chief public health officer who is extremely well respected, credible, and I think extremely able to do an excellent job for Canada in making sure we have good surveillance information coming through the WHO, the CDC in Atlanta and other areas so that we're not caught unawares of outbreaks or emerging diseases that may be occurring in other countries. Secondly, the provinces, territories and local levels are working together much better. Certainly in the Ontario context I have received nothing but offers of assistance, lots of advice, many offers of support from local medical officers of health and from a variety of health care practitioners and hospitals in other settings. No one wants to see a repeat of things that go wrong; they want to learn from that and do it better next time.

The Chair: Mr Arthurs?

Mr Wayne Arthurs (Pickering-Ajax-Uxbridge): My question is around the area of cancer care and Cancer Care Ontario. Perhaps I could just premise it with an acknowledgement of the fine work done by the thousands of individuals this weekend in walking, running, pushing strollers and raising some $19 million for breast cancer research. I think it's a pretty good indicator of the engagement of the public in our health care system from their own private and personal efforts. I know Mr O'Toole and myself have a particular interest in the Lakeridge Health site, in which there's a Durham facility currently under construction that went through a long process of approvals through multiple governments and public engagement.

I note in the estimates that there is some $360 million or thereabouts for Cancer Care Ontario, increased this year by about $52 million, some 16%, which is certainly well above the rate of inflation and well above what might go to the hospital system. What do you expect, Minister, as outcomes from the additional funding, some $51 million or $52 million being allocated to Cancer Care Ontario for research and work in the cancer area?

Hon Mr Smitherman: The additional funding that is allocated to Cancer Care Ontario is in a certain sense a continuation of the trend line. The trend line, of course, that's facing us in the province of Ontario and facing people very personally as family members and as patients is that we have a pretty significant growing disease pattern with respect to cancer. This is causing a very significant expansion and therefore ongoing investment in our cancer infrastructure. You make the point that in Durham region we're building a new facility at Lakeridge. I'm pleased to see that the program is ongoing.

Perhaps what would be helpful would be to highlight just some of the areas where the additional funding is being attributed: $10 million, approximately, for the delivery of radiation and systemic therapy, which is an increase of 7.5% in volume on those services; a 5.1% increase in new case volume; $29 million for integration of the 2,100 staff. So this is an important piece of the contribution. As the staff of Cancer Care Ontario were transferred to operation of the host hospitals, there were some costs associated with that. This assists it.

In fact, the number, in a certain sense, is already understated. This will go back to some issues in the Legislature that the Chair and I have had the opportunity to engage in, and that is around the new drug funding program. We have, in-year, already made one significant new allocation of resources for new drugs, for program growth. We have an expectation, with a significant portion of 2004-05 yet to go, that there will be a further in-year allocation that's necessary in order to support those programs.

The last point I'd make is that we should expect as a province to continue to need to align additional resources behind the fight against cancer. We're obviously extraordinarily aided in this endeavour by two things which are really noteworthy. The first is just the extraordinary capacities we have in our province in the form of the talented women and men who work on the front lines of delivering health care to those people who are struggling with cancer, and also those women and men in research who are contributing so much to those causes. And then, to make the point, especially after the kind of outpouring of support we've seen not just this past weekend but with the walk, there is obviously an enormous amount of community-based focus on the challenges around cancer. Individual patients in Ontario continue to benefit every single day from the fact that there is so much local fundraising initiative going on to help support what is obviously still a very, very pressing demand for cancer services.

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I would just like to follow up a little bit on the theme that the member for Markham raised around prevention. I gave a lengthy answer about the resources that were required to align behind the fight against cancer. The fact of the matter is that a lot of power here is also in the hands of individuals. Government has a responsibility to stand up and try to encourage people to assist them in staying off tobacco in the first place or dropping it as a habit if it's something that they've picked up.

We have a very aggressive tobacco strategy forthcoming, a piece of legislation that has been much talked about and is the subject of significant progress. I really do believe that we can demonstrate significant progress on the prevention side, keeping in mind the sobering reality, which is that tobacco-related cancer alone currently robs us of 16,000 people every year in Ontario. That robs us of their contribution in the community and it robs families of loved ones. This is a pretty compelling piece of evidence, and that's why we're going to move forward in such an aggressive way with a comprehensive tobacco strategy that, as I've mentioned earlier, has been lacking in Ontario really going back, most people around

these files would say, to the point that Ruth Grier was the health minister in the province of Ontario.

Mr Arthurs: Thank you, Minister. To change gears almost entirely, can you give us a bit of an update on what the status is and expectations are on the child vaccine programs announced earlier in the year?

Hon Mr Smitherman: Dr Basrur or Dr Kurji might be better able to give some more detail on our program around child vaccinations. I'll tell you that I'm pretty proud of that program. I gauge some of this stuff by what people come up and talk to me about at community events or when I'm walking home, and the like. This is one that really touched a chord, of course, especially for families, not just because they were being forced to foot a bill, but any time you've got something that's available that can protect our kids and have the incredibly powerful impact as well of helping address some of the challenges around hospitalization, government should move forward.

We encouraged the federal government soon after we arrived here to make some funding available. They did make money available on an interim basis. This has given us the opportunity to get a program up and running, but after three years this will be money that the taxpayers of Ontario, the people who are paying tax into the province as opposed to the federal government, will have to foot.

Having said all that, we're proud about what this program can achieve and we've been excited by the response that's been received at the community level. I think Dr Basrur could be helpful in giving some sense of the scope of this program.

Dr Basrur: As the minister said, the three new childhood vaccines that are being funded starting this fiscal year will include: meningococcal vaccine, which helps prevent invasive meningococcal disease, the cause of meningitis, septicemia, mental retardation, premature death etc; varicella, or a chickenpox vaccine; and pneumococcal vaccine, pneumococcus being a bacterium that can cause a variety of illnesses, particularly pneumonia, meningitis, septicemia and the like. The age groups that are particularly at risk for these conditions can be the very young, very sick, very old and, in the case of meningococcal disease, there is also a recurrence of its incidence in the teenage years. So the program has been designed around the epidemiological facts of the disease and how it occurs in populations.

We've used the available money to its best effect to ensure that we're building on programs that currently exist in the community either through the local health units and/or local community physicians.

If the honourable members are interested, I can provide further detail on who's eligible, when, and so forth.

The Chair: Thank you, Mr Arthurs. Your time is complete.

Mr Arthurs: Is it currently rolled out?

Dr Basrur: It is in the process of being rolled out. Actually, of these vaccines, there has been a gradual increase in eligibility, going back to July 2004, with pneumococcal vaccine for all high-risk children. And from January 2005, it will—

The Chair: I believe the answer is they have already begun. If you can give a fulsome report to Mr Arthurs, it would be helpful, but they are—

Hon Mr Smitherman: We'll circulate it.

The Chair: Thank you. A quick question?

Interjection.

The Chair: Well, you have the floor. Who am I recognizing? Mr Baird.

Mr John O'Toole (Durham): We have a point of order here.

Mr Baird: I learned that Mr Wilson is unexpectedly attending a funeral, and we have the votes on these estimates at the end of the day. So I wanted to ask for unanimous consent to use a sub for him, after the 9:30 deadline.

The Chair: Is there unanimous consent to agree to the sub for him? Agreed. Thank you.

Mr O'Toole: I have a couple of areas I'd like to comment on and maybe a couple of questions at the end—nothing too insightful. I had the privilege of working in the Ministry of Health for a couple of years and learned a considerable amount and contributed a very little amount, actually. But I did learn a lot and I really respect the people there.

Hon Mr Smitherman: That's not what my briefing notes say.

Mr O'Toole: I would just say, if you're not learning, you're not listening. Hopefully that's what you—

Interjection.

Mr O'Toole: Yes. Anyway, we'll keep this at a very professional level.

The first one is Lakeridge Health and its current challenges. As Mr Baird has outlined for the Ottawa area, it's my duty and privilege to represent the Durham riding, which includes very complex issues that I will bring in some detail in a moment.

The second one is the whole idea of your election commitment, the waiting list issue. I think it's fancy wording and I'd like some clarification on waiting how long. Everyone wants to wait shorter. I want to know what the benchmarking is, when that starts and when it will be made clear to the public how long is appropriate for what services.

The number three issue I want to mention in some detail is the doctor shortage issue. I have three areas with under-service issues: Port Perry, Bowmanville and Oshawa. In fact, I wrote two or three years ago to the medical officer of health for our area and asked them at the Durham regional level to declare the whole region underserviced. We're spending all this money on these consultants going around listening to stakeholder input. You'd have to be brain dead not to know that we're completely underserviced in every area, yet we spend about $100,000 going through this litigious type of exercise, which I think is less imaginative than what we could do, as publicly elected people. In that area, under the doctor shortage, I want to know something about the

nurse practitioner role and its expansion into scope-of-practice issues, and your new term, LHINs, for family health networks. There's something I would like to ask about there.

Number four: Dr Basrur was mentioning something about the lack of infrastructure on the IT side. Maybe I'll make a couple of comments there, as that was the area that I spent most of my time with, the Smart Systems for Health or the NORTH Network or the e-Health initiatives, in all of which we invested a considerable amount of money. When I looked at other provinces, we were so far ahead that when Radwanski, who was then the Privacy Commissioner, came here to appear before a committee, I couldn't believe how out of sync he was with where we were going on health privacy matters, which were imperative in those policy-level decisions before we developed the infrastructure for warehousing of personal information.

Those are the four areas I'd like to mention in more specifics on the second round.

I've met with the Lakeridge Health board—Anne Wright and Brian Lemon—on a number of occasions more recently. As I understand it today—I'm certain they have written to you or to John, the ministry director—they have a $19.4-million deficit this year, accumulating to $23.1 million next year, for a total in 2005-06 of $42.5 million. It goes back to Mr Baird's point earlier about what are they going to cut. I'm just going to mention a couple of things. It's a multi-site facility. All of this I'm just doing to be able to communicate with my constituents in a copy of Hansard. That's why I'm doing it really, to put a voice on the official record of what my constituents are telling me.

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In a real case there are many diverse community needs, like in Port Perry. It's an excellent community hospital. It has a clinic kind of environment, and the leadership there, as you mentioned yesterday, Minister, is remarkable in the clinical world, I guess you'd call it. I think Dr Stewart is the one who did the study on the overuse of antibiotics, but there are other leaders as well. A lot of new doctors are recruited there because of the team environment. It's excellent. It should be a perfect model.

I worked with Dr Ruth Wilson—she visited the doctors there—to try to have them join a family health network. The whole issue came down to technology—who is paying for it, the licensing and all the stuff—and who is paying for the nurse practitioner. I think she would have recommended—and hopefully she is still on the job, because I found her very professional—to find a solution there to get them to work together. It all comes down to money, basically. They will roster more patients if you solve those two issues, for sure. They would probably increase the rostering caseload by as much as 20%, and that's really what it is: rostered practice. I kind of support that solution.

Very specifically, in the Lakeridge site model problem, the Port Perry community is absolutely polarized on the issue of providing birthing and supportive pediatric services at that site. They will not give it up. I'll be supporting them, obviously, because I get elected there. That's what this comes down to in the popular sense. There is capacity at Lakeridge Oshawa, all kinds of it. Bowmanville gave up their site but they got an ophthalmology program, the Eye Centre, in Bowmanville. They were prepared to give up their birthing centre.

This is a very emotional issue and it's hard for you. I empathize with you because you're going to take these underutilized capacities out of one hospital and just put them in another, whether it's cancer or whatever. Do you understand? This is huge. I don't know how you can get around it. You've got to be very clear on that. That's a case where Dr Cahoon, who was the chief medical staff for that site at one time, an eminently respected key stakeholder in the area—he is now sort of retired from active practice. I think he's doing some consulting work. He's now on the Lakeridge board, with the intent of having a lot more technical input on the board. As you know, these are corporate-type decisions. Good luck, because they won't be taking any money or any services out of Port Perry.

If you look at that whole Lakeridge challenge, the multi-site, dialysis issues, I knew, when the Health Services Restructuring Commission was going through there—having served on a health and social services committee locally, I'm fairly familiar with the struggle, as is Wayne Arthurs—this is a huge issue. If you look at your new model of organizing health providers by regions, if you will, somebody would wonder why we had the Rouge Valley and the Lakeridge Health splitting Durham region, when all the regional health services are supposed to be aligned. So there are things that could be done that aren't money that could make it more logical for the residential base. But I'm just going to mention that program, the birthing issue—huge issue—and I'm sure it's the same in every other region.

This shortfall in money, as Mr Baird has pointed out, is chronic, systemic and historic. It's not related to ideology. If the hospitals start backing up your emergency—bingo—you're on the front page and you're out of a job. They'll put somebody else in. They'll put Sandra Pupatello in there or something. That's the way it is, because they can put you on the front page in a matter of a week. Toronto did it to us weekly. Backed-up emergency—bingo—people in the hallway; CBC comes in, 6 o'clock news and the minister is in trouble the next morning. It's story time.

The next thing I wanted to mention was that we had lots of problems, and this is just one example of many, of the utilization capacity of the Eye Centre in Bowmanville. They were servicing quite a large catchment area. Durham region has over 500,000 people, plus there are Northumberland and Peterborough people taking advantage of that. They had ophthalmologists—the specialists who do this procedure is a whole separate, subordinated issue—but it's a who-can-do-the-procedure kind of issue. Who gets the operating room time is the deal.

There was a huge problem of customer waiting lists. So when you talk about waiting lists, I'm dealing with people who have scheduled time off work, scheduled child care or home care or whatever kind of supports they need to do this procedure, and then the procedure is cancelled because some anaesthesiologist is on vacation or whatever, some problem, and we're told there's no more money. I understand that you've committed to an additional 9,000 procedures for cataract; I think I read that. We're counting on that kind of service.

Waiting lists are really what I'm talking about as they apply to the community, and waiting lists aren't unique to hospitals. I'm dealing currently with a family that has a mother in the early stage of recovery, hopefully. It could be the latter stage of life; it's hard to say. I've written to you on this. I won't mention the person's name for personal reasons, but I have written to you just recently. The daughter has taken a considerable amount of time off work, to the potential risk of her own family, and she is being put on a priority list. Under orders from the doctor on the discharge plan from the hospital they were supposed to receive personal support, and medical support, I think, but they hit the two-hour-maximum benefit. Basically the person can't stay home alone, not unlike the issue Ms Martel is raising. If you're going to look at individual cases—and the CCACs in my area seem to have large waiting lists.

On the waiting list specifically, Minister, there's a question: What is the appropriate waiting time for hip, knee, cardiac, whatever? I want to know where you're starting so that in 2007 I can say, "Good for you. You made it." But if you're just going to say the big story is waiting lists and not tell me when you're pressing the go button, what's the benchmark? I want to know what your benchmarks are on these particular services, whether it's cancer—what's appropriate? Any amount of time for my constituents is inappropriate. I'm just saying that's the reality. If their mother, father, sister or brother has cancer, they want the treatment the next day. So I don't know how you can win on it. No one tried harder than Elizabeth Witmer. Some would say she ran away with the chequebook, but somebody else got the cheques. We spent a ton and got not as much as we would have liked.

On the doctor shortage issue, I'm interested in whatever acronym you use to call these primary care providers: pharmacists, and hopefully physiotherapists would be in that, but you've delisted them, more or less. They're part of the rehabilitation group that should be there as the health provider team that you keep referring to. I think that is the future, it is the direction, and without it you're in big trouble there. All the doctors want to be on salary, with a pension attached to it.

I also think, more imaginatively, expanding the role of the nurse practitioner would be a bit of a stick in the eye for the OMA, if you expand their scope so they could do prescribed acts, controlled acts, all these various technical things I don't know much about, except I know they exist through the college. Have you done anything in that area? That would be quite imaginative, cost-effective and would create some, if you will, minor competition with providers.

I have been in meetings, Minister, where doctors have told me—no press involved in these meetings—they're not doing all the heavy lifting. They like some of the flu cases or broken fingernail stuff just to do the billing. If they were going to get all the heavier caseload, you'd have to rejig the whole fee-for-service schedule because they're not doing all the heavy lifting. They've told me in private meetings, groups of 10 and 15 physicians, all of whom I respect, by the way. My physicians are a husband-and-wife team. I won't mention their names either, but they're in the Courtice Medical Clinic. They're both retiring at the end of the month and my wife and I have had them—now that I'm over 60 and I need their help, they're leaving. I can't believe it. I don't think anybody would want me. But I would like a response on that.

The IT issue: It's my understanding that the province of Ontario is basically the leader in integration. The issue there remains on health privacy, patient information records. We already have exemplary models—too many of them, perhaps—across Ontario of excellent HR and patient record information. We even share digitized information on diagnostic equipment and lab results. We're doing a lot of that under the nine modules of the Smart Systems for Health Agency.

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I see you're putting $35 million, I think, into the IT cluster. Is this going to improve what Dr Basrur referred to as an inadequate system for patient tracking? All of that is really basically tied to public health provision of service, because they are part of those modules of smart systems. With that bundle—I try to use half the time and give you half the time to respond. I did cover four areas.

Hon Mr Smitherman: I could have done that.

Mr O'Toole: Yes, you have this standard package of blah blah blah.

Hon Mr Smitherman: I get paid by the word.

Mr O'Toole: Paid by the word. Good.

Mr Baird: You put Elizabeth Witmer and Frances Lankin—

Mr O'Toole: Exactly. Frances Lankin can talk longer than anyone.

The Chair: Minister, just to let you know that you've got four minutes to respond.

Hon Mr Smitherman: I want to say on the issue of Lakeridge overall, of our $469.5-million funding increase, they were a beneficiary of $2.1 million. This contrasts, as an example, with the record of the previous government which, in 1996-97, cut hospital funding by 3.5% or, in the 1997-98 fiscal year, cut hospital funding by 4.4%. In those two years, they reduced hospital funding by $557 million on transfers. This is while they were closing 28 hospitals in the province.

I just want to say that the last budget they brought in, the Magna budget, indicated that their forecast for hospital funding this year was $700 million below what we have actually allocated.

With respect to the issues at Port Perry, I have had the chance to meet with the mayor and with many of the communities with the smaller hospitals in the networked hospitals that have really felt that a lot of the migration of services has been to the larger hospitals in the network.

The message I send to all Ontario communities is that their hospitals have a proud history and a bright future, but the future should not be confused with the status quo. In other words, we shouldn't suggest, as an example, that an obstetrics program, if volumes dictate, shouldn't be moved because it has always been there. If the evidence is clear—and in the case of obstetrics, it tends to be—that clinical volumes or, in other words, a hospital doing more births has a healthier outcome for baby and mom alike, we shouldn't hold on to those programs just because they've been there historically. I don't know the volumes on Port Perry, but I just want to make that comment overall.

When I met with the mayor of Port Perry, what I said was that I wanted to work within the system, and I've been doing that, to make sure we find a valued role that each hospital can celebrate. Bowmanville stands out as a terrific example.

Before I get there, one last point on Port Perry. When you went with Ruth Wilson, whom we have really reassigned in the same role because she is a woman of extraordinary calibre who offers so much to our province, the things that were missing—a nurse practitioner and technology money—are things that, as a result of initiatives that we've undertaken, will now be available.

Family health teams, on a basis of rostering, mean that nurse practitioner funding will be possible. We, as a government, fulfilled a commitment that your government had made in the OMA agreement it signed, which was to provide money for physician technology. When we arrived, even though the agreement was at its end, that was a bill that had gone unpaid to date. We've flowed those funds, and that means that on both of those points, those physicians would encounter more opportunity to fit within the models that we're working on.

In Bowmanville, what I want to say is this: Your community hospital there and the program around cataracts is a celebrated program of the Ontario health care system. As we seek—and this will occur very soon—to expand volumes, I would think that it's a reasonable expectation that Bowmanville will continue to be a place that we invest in. I can't make a commitment that they will get increased volumes, because we want hospitals, frankly, to be competing somewhat for those, but Bowmanville, on its record, is well placed on that.

Wait times is an issue that is a bit complex, but here is the simple point: Saskatchewan is the place in the land that pretty much everybody agrees is further ahead of everybody else. What we're doing to build a wait-time strategy, to get to the point that we can say, "This is a clinically appropriate standard and this is how we're doing measured against it," is to adapt the Saskatchewan model for Ontario. That's the fast-forward point. Way better than that, we've got the same guy, Dr Peter Glynn, who's from Kingston and has been working on this project for Saskatchewan, assisting us, working alongside Dr Alan Hudson.

By next year, we will start to put all of the wait-time information that we can assemble on a Web site and use the Ontario Health Quality Council to begin to report this. This will evolve over time, because Ontario, frankly, on the date of collection for appropriate wait times, does lag behind because doctors have historically been the source of this information and so it has been very difficult to bring together. We're making great strides on it.

Mr O'Toole: Are you using CIHI?

The Chair: There is little time left.

Hon Mr Smitherman: CIHI—we're using ICES, the Institute for Clinical Evaluative Sciences, that's linked to Sunnybrook. Dr Glynn is the chair of that board, and they're our partner in it.

Did you say "time"? I'm sorry, Mr Chair.

The Chair: Yes.

Hon Mr Smitherman: Could I have just 30 seconds longer?

On the issue of technology infrastructure, I would agree that as you travel around Ontario there are some tremendous examples of technology, but I would make a very strong criticism, which is that we have not implemented technology; we've moved forward with different pieces of platform in different places unequally and we have this patchwork quilt. We're trying to refocus smart systems a little bit more toward our transformation initiatives to make sure that the priority focus we bring to issues is on a parallel track with the priority investments in information technology.

Underscoring this point is the commitment we're making to building the appropriate public health technological infrastructure. Those are initiatives that were undertaken in response to SARS early on by your government and that we have just propelled forward this year—in this case, more than $12 million of additional resources to get that deployed across all public health units in the province of Ontario. It started in Toronto and York, for very obvious reasons, and we're spending 12 million bucks this year to get that deployed more broadly across public health units.

The Chair: Ms Martel, you have 20 minutes.

Ms Martel: I have some questions on community mental health. First, I'd like a clarification of the vote itself. On June 14 the announcement for funding for community mental health agencies was for $65 million. The vote in the estimates on page 133 shows a vote of $62.8 million. On page 134, the change in funding actually shows $60 million. So can I get a clarification? Was there money that was underspent that was applied?

The Chair: We welcome back Mr George Zegarac, the assistant deputy minister, community health division.

Mr Zegarac: The amount, as the minister has said, is $65 million. Of that, $60 million was the community mental health allocation, plus $1.48 million for some mental health supportive housing. There is some pay

equity funding in there. That brings us up to another $800,000 that we allocated to substance abuse and problem gambling. That brought us to $63 million—this is on page 134. The remaining $1.3 million is basically some pressures that we continue to fund, and we found the money from within to reallocate that allocation.

Ms Martel: Just to be clear: The actual amount that's going out to agencies, does it include the proxy pay equity? Is it pay equity for agencies as well?

Mr Zegarac: It does.

Ms Martel: So what is going to agencies would be what shows on the line, $62.8 million, plus the $1.4 million? Am I correct?

Mr Zegarac: Right.

Ms Martel: Can you tell me, do the agencies have that money now?

Mr Zegarac: The funding allocation—I know the letters have gone out for those portions and there's one further allocation that will come up shortly.

Ms Martel: I'm making a distinction again between letters and money.

Interjection.

Ms Martel: Yes, we have. I just want to know: Have they received the money or the letters? Which?

Mr Zegarac: Letters.

Ms Martel: When do you anticipate they will receive the money?

Mr Zegarac: Let me just check with Rob.

There's a sign-back requirement. We are getting the funding out as quickly as possible as those sign-backs come in. There's one further allocation that will come out as we look at dealing with some other community supports that need some further decisions from the government.

Ms Martel: I'm not sure I understand the matter of one further allocation. Can I break this down into two questions? You've said some have gone out. I don't know; there were a lot of agencies listed in the press release. Have the majority of the agencies received their money, and can you tell me what the issue is around one further allocation?

Hon Mr Smitherman: George can follow up. On the one further allocation is an element of a new program which we've been advancing through the policy process and which is coming shortly for announcement. It's a very targeted initiative that's developed in concert with some other government ministries. It's coming forward for announcement reasonably soon.

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Ms Martel: One other question, then: Is that part of the $65 million, or will that be new money?

Hon Mr Smitherman: Yes.

Ms Martel: OK, thank you. My other question was the agencies that are receiving money. Have the majority received money?

Mr Zegarac: I'll introduce Robert Moore, who's our acting director for mental health. He can answer the details on the funding.

Mr Robert Moore: Some of the funding was used to stabilize programs. So in some cases, we had been managing some resources. We have secured the base for those resources and they'll continue on. There have been some programs where there's a base increase of 2%. There was a sign-back process. Again, strong accountability and somewhat new accountability measures were put into place for this money. So in some cases, on a region-by-region, program-by-program basis, some programs have received cash flow. The majority have not at this point.

Ms Martel: Actually, that was going to be my next question, what was the percentage increase in the base budget per agency. Was it a 2% increase across the base for everybody?

Mr Moore: Correct.

Ms Martel: Maybe you can't answer this, but what does that mean in terms of either the agencies' ability to retain staff, which might have been their first priority, or, secondly, the agencies' ability to hire new staff?

Mr Moore: Again, it's a case-by-case basis. It's hard to give you an overall, but it would support both of those, to some degree.

Ms Martel: But it would be hard for you to tell what the addition to base really did, either in terms of essentially just retaining the staff that were there or actually giving the agency the ability to hire new. You can't tell that yet.

Mr Moore: It would primarily be probably to stabilize the existing base, not just staff, but also other kinds of administrative overhead.

Ms Martel: Just flowing from that, with the stabilization of the existing staff, does that mean it probably won't have an impact on waiting lists this year because the money was just actually to hang on to the staff so they could continue to deal with the clients they already had?

Mr Zegarac: If I can just add—and Rob can join in—there's a base increase that's out to stabilize the mental health agencies. There's also enhanced funding, and that's the funding that we'll be providing. Further funding will be announced shortly, and that's to provide additional care. There are targets that have been identified for that care, and that's part of the sign-back provision. So there will be enhanced activity that's not just paying for what we get right now.

Ms Martel: OK, but the enhanced funding—is that going to be added to base, or is that for one-time-only special projects?

Mr Moore: That would be base resources as well, but it would be for new services, additional services.

Ms Martel: So will that take the base budget up past 2% for some agencies?

Mr Moore: In some cases, yes.

Ms Martel: But I'm assuming not every agency will get enhanced funding.

Mr Moore: No.

Ms Martel: Do you have a sense, among the agencies—a quarter? A third? A half?

Mr Moore: I have that information, but there are about 350 agencies. I would be guessing. I'd rather confirm the actual number, but it's a smaller percentage of organizations getting the additional new service dollars.

Ms Martel: And the new services will be where we will essentially see a change or an impact on a waiting list.

Mr Moore: Yes.

Ms Martel: That'd be correct? OK.

I just wanted to ask, in relation to community mental health services, the obvious link to addiction services: Their budgets were flatlined this year; is that correct?

Mr Moore: Correct.

Ms Martel: We have some serious situations at home, which I won't get into here. I'm sure that can be repeated across the province. I'm wondering, Minister, though, can you give us some indication of when you see the addiction side of the community-based services getting some addition to base budget?

Hon Mr Smitherman: I can't make next year's budget here, of course, but I think, in a question asked earlier today by my colleague from Markham, I acknowledged that this is one of those areas where we've still got some work to do. I think I've been pretty up front with the sector in saying that we recognize the stresses that they're under. I represent a downtown Toronto riding, so it's not lost on me that we've got to get some additional supports in there. I'd hope to be able to accomplish that in the next fiscal year. It's not a commitment that I'm in the position to make right now, but that would be my hope.

Ms Martel: Thank you very much. Can I move, then, to the tobacco strategy, which appears in our estimates on page 93? Under "Funding Increases," I note that there is implementation of the tobacco strategy—$31 million. Can I ask how you see that $31 million being allocated?

Hon Mr Smitherman: I'm going to get Dr Basrur to offer more detail. Usually, when I say that, I talk for four minutes and say most of the stuff, so I'll try to talk only for maybe 90 seconds and do that.

We think it's appropriate in developing a tobacco strategy that it be comprehensive. By that I mean that we have initiatives that are designed in a certain sense to stem the tide of those who might pick up a cigarette and become addicted to it and to assist those who have already fallen prey to that habit to quit. So there's a combination of matters associated with our comprehensive strategy. There's a significant marketing element related to it, as but one example. But I'll get Dr Basrur to walk you through in more detail exactly what's coming down the pipeline.

Dr Basrur: Without stealing the government's own thunder, let me say that the comprehensive tobacco strategy that the minister referred to was part of the platform commitments of the Liberals while they were in opposition and, as you are aware, included a number of elements, including but not limited to legislation that would make Ontario's public places and workplaces smoke-free. In addition, there was a commitment in that platform to learning from the best practices and experiences in other jurisdictions, some of which are in the United States, some of which are contained in best practice guidelines from the Centers for Disease Control.

I would expect that living up to that commitment will enable a program to be brought forward that encompasses everything from clean indoor air and protection of workers and inhabitants of public places through to prevention, particularly focusing on children and youth at their most vulnerable ages to enable them to have the knowledge, skills and attitudes they need to resist peer and other media influences, as well as cessation to enable those who are already hooked to try to quit before it's too late.

Ms Martel: Dr Basrur, I'm very glad you mentioned the Liberal commitment because I was just going to head into that next. The concern I have, frankly, is that the commitment in terms of funding for year one for the tobacco strategy outlined in the election campaign last year was $140 million. What I see in the estimates is $31 million. So what I do see is a significant shortfall from the election commitment to what I gather the ministry is going to fund this year.

Let me just give you some of the details. The Liberal backgrounder said that there would be $31 million a year spent on a youth mass media campaign. Secondly, there would be $12.5 million a year spent on the legislation of 100% smoke-free workplaces. Granted, that legislation is not here, so let's just take out the $12 million for this year, in all fairness. But the smoking cessation programs that included telephone-based programs, promotion and support of primary care cessation counselling, primary care cessation services, including counselling, smoking cessation medication subsidization—that total every year was a commitment of $46.5 million and there was also a commitment to a one-time community transition fund of $50 million. So the Liberal commitment in the election campaign was actually a total of $140 million in the first year, dropping down to $90 million in the second year; I gather that had to do with the one-time transition fund. So we're more than a little short in terms of the money at the same time that the money from the increase in tax revenue on cigarettes has actually increased quite dramatically. The projected new revenue in fiscal 2004-05 from the change in tax policy on cigarettes is $90 million and the increased revenue in 2005-06 is $110 million. I'm just wondering why there's such a significant shortfall in funding for this program this fiscal year when the commitment was so much greater.

Hon Mr Smitherman: I think what it reflects is the reality, which is that this fiscal year is ticking along and across the wide variety of priorities that we have this is one that from a timetabling standpoint is obviously not going to be in play till toward the latter part of fiscal 2004-05. So what you have here is a recognition of that reality, plus, to the point that you've made, which is that at least on the costing, as an example, associated with the legislative element therefor, that's not a required expenditure.

I do think that what you will see is that the government of Ontario has a substantial investment to make in a comprehensive strategy to address this number one preventable cause of death in Ontario. Particularly over the period of the length of our term, you will see a significant ramp-up that gives us the capacity to strengthen the fight. But the number for this year reflects the fact that from the get-go we recognize that with all of the other things we had to timetable, from a parliamentary calendar standpoint and also from an internal government process standpoint, this is an appropriate amount of money to get our campaign launched in 2004-05, with build-up in subsequent years.

1400

Ms Martel: I'll take your word for it. I didn't put out the costing platform, you folks did.

Is the community transition fund an allocation that's going to be made or not?

Hon Mr Smitherman: Although this is captured in a political characterization that you're using, this is a matter that is the responsibility and domain of the Minister of Agriculture and Food.

Ms Martel: I understand that it came under the tobacco strategy, though, in terms of your commitments.

Hon Mr Smitherman: It's not in our estimates that way, obviously.

Ms Martel: Can you confirm it's in his estimates?

Hon Mr Smitherman: I can confirm that I'm before you today with the estimates from the Ministry of Health. I think it's important that the Minister of Agriculture and Food is the lead on that element of the strategy.

Ms Martel: OK, let's take the community transition fund out of your estimates. We'll give you a break and take out the smoke-free workplaces, because we presume the legislation is not going to be in place to have an allocation this year from that fund.

In terms of the mass media campaign targeted at youth and the smoking cessation programs, can you give us a clearer idea of what the breakdown of the $31 million will be between those two items?

Hon Mr Smitherman: I'm not in a position to do so, but I can confirm that the amount of money we have in our allocation is a sufficient and substantial amount of money and, particularly because of the fact that we're working now on a prorated portion of a fiscal year, it will be sufficient to launch those elements.

Ms Martel: Can you tell me in what fiscal year you anticipate being able to match the commitment that was made in the last election?

Hon Mr Smitherman: That will obviously be very evident as we print estimates for years on a going-forward basis.

Ms Martel: But you've received $90 million in new revenue this year alone just from tobacco tax increases. Is there any thought among cabinet that this money should actually be targeted to help support the tobacco strategy so that you have guaranteed funding for that year after year?

Hon Mr Smitherman: I think there was a strong view in cabinet that that money should be spent in a variety of ways, including enhancing our capacity to treat people with cancer in Ontario.

Ms Martel: And it will go into general revenues?

Hon Mr Smitherman: Yes.

Ms Martel: Let me ask a question, then, about an announcement that was made on nurses, in particular graduate nurses, and a mentoring program, on June 3: a $50-million allocation to keep new grads or to hire new grads in hospitals and to implement a mentoring strategy both in hospitals and, I believe, long-term-care facilities. Can you tell me, has this money been allocated to hospitals yet?

Hon Mr Smitherman: It has not.

Ms Martel: Do you have a sense of when it will be?

Hon Mr Smitherman: It will be a fall allocation.

Ms Martel: Can I ask what work is going on behind the scenes to the point where that money hasn't gone out yet?

Hon Mr Smitherman: Substantial policy work within the internal process piece, but also on the profiling of the program, being led by our chief nursing officer, Sue Matthews. We've been working to develop a program that has some complexity associated with it because there's concern from a union standpoint and the like.

This is a program that we think is essential because it addresses the gap right now whereby a lot of our new grads are coming out of school with an inadequacy of training—at least, this is the marketplace's read—given the acuity of patients they'll be dealing with. We're going to spend money to enhance the clinical practice models and give them some of the high-tech equipment that is necessary to enhance their skills. We want to be able to buy some time in Ontario's institutions—hospitals and long-term-care facilities—so that our new grads get some front-line experience.

What we're particularly keen to do is to take advantage of the institutional memory and passion of what are often referred to as senior nurses. We also want to buy some of the time of senior nurses so they can mentor the new grads, thereby making a significant contribution to the overall expertise of the nursing population in Ontario. That program rollout will occur this fall.

Ms Martel: So the policy work is almost done and you anticipate the money can go out this fall?

Hon Mr Smitherman: Yes.

Ms Martel: And is it to hospitals and long-term-care facilities?

Hon Mr Smitherman: Yes, both.

Ms Martel: Do you have an idea of what the breakdown will be between the two?

Hon Mr Smitherman: I do not.

Ms Martel: I forgot a question on community mental health. Sorry.

Hon Mr Smitherman: Do you want George or Robert Moore?

Ms Martel: Why don't I ask the question and you can tell.

The Chair: You have two minutes.

Ms Martel: In the announcement it said there would be an additional 78,000 patients who would be served at the end of the four-year rollout. I want to know how you arrived at that number and what is the base that we're working from.

Hon Mr Smitherman: I think Robert Moore—

Mr Moore: Essentially it's a formula based on existing service capacity and delivery. When you look at the different types of services we're funding, some of them have very set client-to-staff ratios; others are based on information we have from existing services of that type. That's projected based on the rollout of the different dollars that are there.

Ms Martel: What is the fiscal year? The fiscal year for supportive services was 2002-03. Is that the same for—

Mr Moore: Yes.

Ms Martel: So, essentially, applying a pot of money, multiplying it over that number of clients.

Mr Moore: It's a pot of money divided into the different service types that we're funding. Things like case management services, as well as crisis services, early intervention programs and community treatment all have established service ratios. So it's an estimate based on those numbers.

Ms Martel: The starting number for this year would just be the client number, the patient number?

Mr Moore: The additional number is based on the existing service numbers going up from there, so that's the total new number.

Ms Martel: That 78,000 is the new number. What's your starting number?

Mr Moore: I'd have to check that. I don't have that in my head.

Ms Martel: When you get a chance, if you could get that to me, that would be great.

Mr Moore: Sure.

The Chair: Mr McNeely, please.

Mr McNeely: Minister, as a business owner for 30 years, I closely monitored the costs of delivering engineering projects. Delivery of services on budget took up a great deal of my time, with fairly sophisticated project management information systems.

You have made accountability agreements central to controlling costs in health care delivery. These agreements will be signed with most health providers, I believe. Our government has moved ahead, and I'll read from the financial management policies here. "In December 2003, the government tabled an amendment to the Audit Act that would give the office of the Provincial Auditor wider powers, including conducting value-for-money audits of organizations that rely on provincial funding." I think it's going to be very important that 80% of government funding or something like that was not looked at by the Provincial Auditor beforehand.

As a city of Ottawa councillor for many years—I was just there for one term—there was always that wall that you couldn't go behind. I always wanted to know what the cost of delivery of a litre of water was, how that compared with other cities in Ontario and Canada, what it cost per family for waste disposal, what it cost for a kilometre of road maintained. Those were the unit costs that we could never get the comparisons on. I think they're very critical to being able to evaluate a health provider: If it's 44 CCACs that you have in the province, how are they doing, one to the other?

Do you see tying in the accountability agreements with the auditor's work and providing those comparisons so that we can say pretty categorically, "This group is doing well; this group is not doing so well"? Then you can go in and help those that are not. So are value for money and best practices going to be a big part of the government's overall—

Hon Mr Smitherman: You used the words "tying in." To me, that would give rise to the idea of a formal linkage. My instinct is to say that one will inform the other, and it's based on a pretty simple point, which is that although we use the word "system," we have not heretofore created a system that has the capacity to take advantage of a learning over here and quickly spread it across the breadth of a system. This is what I call the medicare advantage, which I think we're missing out on.

One of the realities we face as we start to do that more detailed analysis of what's going on in a variety of institutions is that they're not all equal. One Ontario hospital does not, oftentimes, bear much of a resemblance to the other. I'll give you an example around how this affects a clinical outcome. You have a 100% variance in Ontario on length of stay after hip surgery, where some hospitals are having the patient after the surgery for twice as long as others. This is an example, in a certain sense, I suppose, of what all those reports have pointed to as an opportunity.

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The real place I believe we're going to make progress—you used the phrase "best practices," on disseminating those; I wish I could find a more human word than that—spreading those across the health care system—is local health integration networks. What they're going to do, in a certain sense, is get everybody on the same page, all the folks operating in one part of the province. The member for Durham used the word "region." The organizational principle that underpins these local health integration networks, LHINs as they've become known—people look for these to be really complex, but the real starting point is simple. We've got to get everybody singing from the same hymnbook, working from the same script. We don't have that now in Ontario. You don't have the same set of health care providers working together with the same set of patients in mind.

We're going to create a simple organizational principle that says if you're going to do a good job as a group of health care providers to work with one patient in mind so the patient isn't constantly feeling they're in the hurdles or the steeplechase, we have to at least get the health care providers in the same area working together with the same set of patients in mind. That's the real principle. I think that will mean we'll shrink the number

of points where all those folks come together and make it easier to spread information across the system. It is a substantial piece of the puzzle, being able to use the word "system" without that little asterisk going off in my head that I'm talking about all the time. So I think LHINs are actually going to be the best way to get best practices spread across the breadth of the health care system.

The work of the Provincial Auditor: It's so obvious on its face that this is long since required. To try to explain to the taxpayers that the province pays 80% of the bills at a hospital but that the Provincial Auditor is the person charged by the Ontario Legislature and given significant authority to go in on our account as taxpayers to ask the hard questions and to make reports which sometimes raise things some of us would rather not hear is an important principle. I'm very proud the government is going to expand the powers of the Provincial Auditor to do value-for-money audits in a broader array of what we often refer to as the broader public service. I think this is a reform that's long since overdue.

Mr McNeely: The second question relates to that, because it's equity in funding. The information that comes out in stories we hear in Ottawa in the press you read—the former minister from Nepean-Carleton brings it up—is that we're underfunded at hospital levels in Ottawa. Whether that's true or not is difficult to say. The comparison in our local press says 85% of the provincial average is the funding. You've told me in the past this is not that easy to say.

The legacy of the previous government is that our waiting times are much longer. We had one MRI per 100,000 people in Ottawa, whereas in Toronto you had 2.2. So it was less than 50% service with MRIs. There were people paying $750 and going across the river to Gatineau or to the States and getting the MRI done, or waiting the seven or eight months, which is probably double the provincial average. So it appears that there is underfunding.

What can be done from the ministry's position that will put the facts on the ground so this argument is not there two or three years from now? It will be important to have those facts. It would be very good to get that information out so we would see that Ottawa is being treated fairly or we are not.

Hon Mr Smitherman: I think the first point I would make is that you use MRIs as an example, and, from my point at least, they're a good one. Of the nine new MRIs we've put in motion in the province, announced in Ottawa two weeks ago, Ottawa and the residents of Ottawa are the beneficiaries of two of them. I think that's a good demonstration that says when you have good quality information that shows you where the inadequacies are the greatest, where the services are the least available, if you're allocating precious resources, you should allocate your resources with good knowledge like that. We've done that in this case. That's why Ottawa and the people there are the beneficiaries of two MRIs.

I think the point about geographic inequity is a slightly harder one. I want to make two points. The first is that one must be very careful. I'm a downtown Toronto guy and I have a lot of hospitals in my riding. I have Sick Kids Hospital and I have Toronto General, and I want to focus on the Toronto General site of the University Health Network. I want to focus on those because I think they're important in the answer. Sick Kids Hospital is in Toronto and has a lot of services there, but Sick Kids Hospital is an asset of the Ontario health care system and it's an asset that's available, not unlike CHEO in the Ottawa area, that serves a much broader population base than just where it happens to be situated. Just the straight-up analysis of the numbers doesn't take that into consideration. It doesn't take into consideration that because Toronto General is a place where we do more transplants than anywhere else in Ontario, people from all over the province are coming in, in this case again to my riding, to receive services there. So one needs to be a little bit careful, because some of our hospitals, especially among the academic teaching hospitals, have a very focused role, which often means they are the centre where people are coming from all over the province of Ontario. That's the first one.

The second point is that local health integration networks are going to give us—because we're going to create consistent boundaries, if you will—a leap forward in terms of the quality of the data we collect so that there will actually be more appropriate opportunities for comparative data to be used.

Let me make the point a bit more clearly. My mother lives in Collingwood. I was taking a look at the community of Meaford, which is quite close to where she lives, and I was trying to decide in my head whether the people in Meaford—I was going to look at some data to see where they get their hospital care. Before I looked at the data, I thought, hmm, I wonder if they're going to Owen Sound, where there's a really good quality, significant service community hospital, or to Barrie, where there's also a fairly significant hospital. Evidenced by postal-code-analyzed data, the number one place where the people of Meaford are getting hospital care in the province of Ontario is Toronto.

Local health integration networks are going to create the appropriate parameters for good quality data collection that's going to give us the chance to analyze it and, as we analyze it, to—I'm not sure if this is the best word—repatriate health care services where it's appropriate. You're obviously going to concentrate transplants in a very small number of places because it's such a specialized service that technology and the human resources experience dictate that that's sensible. But in other places, the collection of information that local health integration networks are going to set up is going to give us the chance to make sure that services that can be provided locally are.

That's the thing that guides us. We believe that the best health care is the health care that's found as close to home as possible. That's why I think LHINs are going to give us the chance to answer that geographic or regional debate; I don't know about once and for all, because I suppose it will in a certain sense always rage on, but

we're going to be able to have a more informed debate around it.

Mr McNeely: The third is maybe more of a statement than anything. It's the mental health money that is spent in the Ottawa area. I think over 10 years it moved from institutional at 70% and community at 30% to the reverse. In Ontario as a whole, I understand from the people who deliver the service in our area that you're up to 66% of mental health dollars delivered in the community now. In Ottawa, that's not the case; it's about half of that. I'm just wondering, why is there a difference in certain areas in the delivery of dollars? Just a fast reaction from myself is that it's tied to the hospitals being so tight for the dollars that they're not giving it out to the community. Will that be resolved through the LHINs as well, looking at the provincial situation and trying to make Ottawa similar?

Hon Mr Smitherman: I think it's more likely to be resolved from the mindset of the government, which is determined to see services that are appropriately delivered at the community level delivered there. I think there's a lot of good, informed work that people have been involved in, those mental health task force reports which the previous government commissioned but didn't seem willing to release. We released them. One of the strong messages that's there, of course, is to put mental health resources in the hands of communities. Even if the resource is an acute care bed in an institutional facility, there are many people who believe that more of the decision-making around the appropriate allocation of those beds should be pushed down to the community level.

I find favour with the argument that community-based care, as relates to mental health, is where it's at, that that's where we should be continuing to put emphasis as a government, that investing those resources at the community level is typically going to mean they are more accessible to people at the time that they need them. If we make mental health supports available when they're needed, instead of available only at the point where the person has an acute incident and ends up in a hospital emergency room—I think many of us have probably had the opportunity to be in emergency rooms where they're trying to provide appropriate care to people who are suffering from mental health challenges—we can do a lot of good by getting these resources out to the community and upstream. This is the general approach that we're inclined toward as a government, and it's very consistent with the work of those mental health task force reports. It's one of the best pieces of community engagement that I've seen. So many people were powerfully invested in that. We've made sure, on any investment we've had the opportunity to make with respect to mental health, that we follow the guidance of those reports, because they're the voice of people.

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Mr McNeely: Thus the increase of 15.7%, $62 million this year, in community mental health. Thank you very much.

The Chair: You have a couple of minutes left.

Ms Caroline Di Cocco (Sarnia-Lambton): I wondered, Minister, if you might provide to me an explanation. It has to do with the internationally trained doctors. There's an issue that seems surprising to me, and that is, sometimes they require two years of Canadian experience once they've been approved, gone through some hoops etc. They require a two-year window, if you want to call it, of Canadian experience. Some of them are suggesting that they have to get it out of the province of Ontario. I haven't been able to get a view of that. Do you have any answer or comment to that?

Hon Mr Smitherman: I'd want to look into the specific cases. When I was in your community, I did have the chance to meet perhaps one of the doctors you're speaking about. I would just repeat a bit my message from earlier, that we've really worked to enhance the number of residency spots. That's a necessary piece that people must secure before they can get a licence to go and practise. Why people are being forced to seek that opportunity offshore—or, I should say, outside of Ontario—may have more to do with our residency capacity. As I mentioned earlier, as a government we've moved to increase that.

I think it's a fair point to say that even though we have made progress on this, from 90 to 200 in the span of about a year, there are still many foreign-trained doctors in the province who are clamouring, obviously, for those 200 spots. If we had more resources to be able to do enhanced residency, this would be beneficial. As I mentioned earlier, I believe this may be an area where there will be some additional federal support. But on the specific question that you raise, I'd want to get a bit more information.

Ms Di Cocco: OK. Thank you.

The Chair: That would complete this cycle. We have about 46 minutes left. I'm in the committee's hands, but may I recommend that the remaining time be allocated 15 minutes to each caucus, and perhaps the Liberals might leave a few moments for the minister for his final statement.

Mr Baird: I like 20-20 an item.

The Chair: Somehow I knew he'd be helpful.

Seeing no objection, and in the interest of making sure we get through the estimates today, I would like to proceed. I have an indication that Mr O'Toole has a short question.

Hon Mr Smitherman: Could I, Mr Chair, be indulged for my afternoon march down the hall, and also inform you that my closing statement will consist of really just a few seconds of thank you. To the extent that that alters your plan, I'm not intending to put anyone through any more of my words.

The Chair: I'd hate Hansard to have to record what your closing comments are. But, please, you're excused.

Hon Mr Smitherman: Thanks a lot.

The committee paused briefly.

The Chair: The Chair would like to recognize Mr O'Toole for his 15 minutes.

Mr O'Toole: Thank you, Chair. I may split my time with you, because I really have a couple of observations to make and then there will be some very short questions after that.

I appreciate your comments on mental health reform. I think that's absolutely critical. We did hear a fair amount about it in the roll-up to the election from the various community groups and I would have to say I'm supportive of that. Also, you made some reference to the mental health task force that was commissioned under our government, and one of my questions is around that.

The central east group was headed by Jean Achmatowicz-MacLeod, an extremely capable and compassionate leader. They sent the task force in. I met with the board; the board actually resigned because there seemed to be no rollout of the community mental health component of it. I looked at it and found out that most of the money—the issues were the successor and transition issues. They were going to separate everybody under the old Ministry of Health kind of employer to the new board, I guess, which was going to be umbrellaed under Lakeridge. There was a huge amount of severance money for people who would be doing identically the same job the next day; they had a different badge on their uniform. The successor rights were problematic—I just could not believe it—and there were a couple of others that were delayed. That was where the money was going, Minister.

I'd like you to comment on that, if you've gone over that, because almost all the transitional monies that had been more or less allocated in the budget process were—you couldn't get there from here. Now, I'm not quite finished. If that is a fact, I need you to confirm it and what your action plan is, because the next phase of moving it into the community is not going to happen until that really happens. We have a wonderful facility in Whitby; they have a forensic unit and all the rest of it, and it's extremely important.

The other part is more or less—

Hon Mr Smitherman: I can answer this in about 30 seconds if that's helpful.

Mr O'Toole: OK, sure.

Hon Mr Smitherman: Our plans still include progress on the divestiture of North Bay and Whitby, and the challenge you've highlighted is exactly the right one: that legislation in our province on successor rights does add significant cost to the process of divestiture down to community-based boards. I think earlier I had the opportunity to reference costs associated with 2,100 employees who had previously made that shift within the ministry. But this is a cost that we still expect to bear. I just want to say that we remain very committed to moving forward those processes.

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Mr O'Toole: That's reassuring except for the public, in looking after the public interest. If people were actually losing their jobs, that would be different.

We made that mistake in a number of instances when we were the government. I should stop thinking about that. Ms Rappolt, whom I believe was in the Ministry of Labour at one time, would know that—when we did the hydro restructuring issue. It's the same deal. We just spent a ton of money. The people woke up the next day and went to the same desk and got a frigging lump sum payout. The people of Ontario are paying for that, and it's unacceptable.

Mr Baird: Like Elinor Caplan.

Mr O'Toole: Exactly. She's back again. It's sort of like regurgitation.

You understand that the Health Services Restructuring Commission basically was started under Frances Lankin. It looked at the 230 hospitals and looked at restructuring. Gee, they came up with a number of $1.4 billion or $1.7 billion to do this restructuring of all the hospitals. I saw numbers that were $7 billion. The capital costs were about $7 billion.

Locally I saw that just the one site, Oshawa and Lakeridge, went from a project which was something under $200 million to over $400 million. There was a nice coffee shop at the opening. It was a nice rotunda kind of thing.

The point I'm trying to make here is, you have that very serious capital challenge, and not just in Durham. They have submitted restructuring plans at the Whitby site, the Bowmanville site and the Port Perry site. They transitioned the Uxbridge site into the other network.

Is there a capital freeze? Because this is eminently a huge issue, not just for the cancer centre that's to be built in Oshawa to serve 500,000-plus people but also for the energy plant which is part of their business plan. Is there a capital freeze?

That's kind of tied to the divestiture of the infrastructure under Whitby Mental Health Centre and Central East as well. That's part of the issue.

Hon Mr Smitherman: Whitby doesn't get caught up in capital because it's one of the newest hospitals in the province. But it's certainly a challenge with respect to North Bay.

Here's what I can say about capital. I had a chance a week ago last night to speak to the board chairs and CEOs from the academic teaching hospitals. I said that there are a couple of pretty challenging things—I was going to say "perverse things"—going on related to capital in the province.

The first is that these folks who did the Health Services Restructuring Commission estimating were lowball artists. We continue to struggle. A lot of hospital projects in the province of Ontario under all parties over time have tended really to not hit their marks, so bringing a new era with greater discipline around that is something we're in the midst of doing.

Is there a freeze? I'd say there's a delay. It's a delay that gives us the opportunity to consider more appropriately what we can afford to build.

Here's the second perverse circumstance we encounter: Most people looking to make an investment in new infrastructure are in part measure looking for the cost that can save them in terms of operating. They say, "Well, I have to get rid of that old building and build a

new building," sometimes for $200 million or $300 million.

In the time that has gone by since, we've been operating with less beds, typically, in hospitals. We've found a way to provide more care in other settings and at home and the like, yet we still seem to have capital, on the one hand, moving forward in a fashion which bears no relation to the pressure that it's about to put on operating.

I'll say this to you: We're going to build a lot more hospitals in the province of Ontario. We're going to move forward with a bunch of capital projects because there's a big infrastructure there and pieces of it need to be replaced, but some of the behaviours need to change, and some of the things that we've been doing, typically, make no sense.

I'll give you just one little example that will relate to the work you did around Smart Systems for Health. You know that Smart Systems for Health has built a big server with enough capacity for every hospital in the province of Ontario, yet we're still approving capital projects with server rooms in them. Not any more.

The point here is, the same thing—I mentioned labs earlier, and someone wanted to turn it into privatization. It's not the point at all. But it is a consolidation opportunity where hospitals can share services and gain efficiencies. We need to take more advantage of that. Our capital needs to reflect those decisions. The decisions we make will reflect the reality, which is that once these darned things are built, we have to pay for what's operating within them. So, if operating costs are going to go up $20 million, $30 million, $35 million or $40 million sometimes, on a one-hospital basis, then I think we really have to question whether that's sustainable in the context of our health care system.

The Vice-Chair: Mr Jackson, you have the floor.

Mr Jackson: It's customary at this point in estimates to put on the record a series of additional questions, and so if I might, Minister, I'd like to put a few of those on.

I wrote a letter to you back on January 22 regarding funding for hospices, and I was fortunate enough, through your staff, to gain a meeting with Mary Kardos Burton and Vida Vaitonis—a very productive meeting. We have a tremendous hospice in our community. I have had many conversations with Donna Cansfield, who co-equally shares a passion for this area of health delivery. I was hoping, Minister, that you might respond to my January 22 letter at some point for the Carpenter Hospice, if we could include that request on your list of follow-up items.

I would ask that the individual on your staff responsible for supervising the activities of Ms Caplan in her review make sure that those terms of reference can look at that central issue of hospices. Our government—and I facilitated this, in fact—had to work out an agreement within the agreement of the managed-care model in order to flow funds for the home care component of the palliative treatment in those sites, but it's a terrible mix for staffing. It's lumpy; it's disjointed. I presented a model to your staff last January that could resolve some of those issues. I'd like to have the ministry's assurances that Ms Caplan might consider those items as well.

As it relates to the Ontario drug benefit plan, I had some questions with respect to this. There has been a lot of rhetoric associated with what came out in the paper, and I'm going to try to specifically reiterate the concerns I have. I've studied this matter and I have concerns about the difference between the subtlety in the letter of understanding dated September 22 between yourself and Dr Rapin that talks about prescribing practice versus prescribing guidelines. I would like some response in writing, if I could, to the distinction between those issues around why we would just follow loose guidelines as a means of achieving better health outcomes when many jurisdictions have moved to prescribing guidelines which specifically target health outcomes and monitor in a confidential way the prescribing habits of a physician.

The second question I have is around the issue which my colleague Ms Martel raised. My view of this, putting on my hat as Comsoc critic, would be that we might share your concern that a pregnant woman on welfare should have her drug regimen monitored in order that she receive better health outcomes, but I think in this province all women who are pregnant should receive co-equal treatment by their physicians—

Hon Mr Smitherman: And nutritional supplements.

Mr Jackson: And nutritional supplements; the point being that good health policy would apply to all citizens regardless of their income. I think that's the point that Ms Martel was raising yesterday and one that bears some further explanation—not at this moment, but I use that as an example because I think it demonstrates, first of all, areas of concern that should be addressed. For me personally, I believe that prescribing guidelines, as they have in at least two provinces now in this country, are the appropriate way to go. It causes a higher degree of discipline among physicians, in terms of their training and their practice, to ensure that.

Third, Minister, I would like you to speak to or check out a small, little-known program called seniors' safe medication use, which I developed several years ago. I know you have benefited from it as an MPP and passed it on. My understanding is that the minister has not indicated whether or not he will continue the support for that program, and I think, based on the comments you made over the course of the two days, it's very clear that for $75,000, with $25,000 coming from the private sector to help promote this, the Ontario Pharmacists' Association can get on with that good work, and if you would speak to the minister involved, that would be deeply appreciated.

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I guess I could raise the same on behalf of the Ontario Residential Care Association, which has its complaints line. I know that you have demonstrated throughout your political career, both at city hall and here, a concern that there is some sort of complaints advice and support line for persons wanting assistance when they're dealing with the unregulated residential care sector, and you might

again speak to the minister, as this is a healthy program for our province.

Finally, Minister, in the preceding estimates back in June for the Ministry of Finance, the minister confirmed that there was a potential of $660 million worth of savings that will accrue to the government of Ontario by delaying capital and by delaying program transfers. Again, my colleague Ms Martel has raised some specific questions about the difference between a letter and the funding flowing. Minister Sorbara was very forthcoming that these program and capital delays were across all ministries but that he did not have the details and that we were to ask for those of individual ministers. So my final request is if you could furnish us with the list of those capital projects and those programs that will be delayed and whatever cabinet document sets out your ministry's contribution to Minister Sorbara's objective of a $660-million saving. If you could provide those details to this committee, that would be extremely helpful.

Finally, I just want to—

The Vice-Chair: We're over time, but just quickly.

Mr Jackson: I wanted to thank staff for being so forthcoming and for participating, but I can do that when I'm Chair.

The Vice-Chair: I'll take that time, then.

Ms Martel: I have some questions about the commitment for new services, so I'd like to get some indication of the money and how the figure was arrived at. For example, the government's commitment is to increase cardiac procedures by more than 36,000 by 2007-08. I'd like to just confirm the funding allocation attached to that commitment and how the 36,000 was arrived at.

Hon Mr Smitherman: Peter Finkle—I don't know his title. I know it starts with A for acting, but the rest of it is lost on me. This is Peter Finkle.

The Chair: Welcome, Peter. What's your title? We have your name.

Mr Peter Finkle: I'm the acting director of hospitals branch and I'm executive lead for multi-year funding and accountability agreements.

The Chair: Thank you. Welcome

Mr Finkle: The 36,000 is a figure that stretches over four years, so it's really a continuation of work that we have been doing with all of the hospitals that deliver priority programs in the cardiac services area and it's an amalgam of the planning estimates that we do with the hospitals—we don't do these on our own—broken down between angioplasty, PCI—percutaneous cardiac services—and cardiac surgery, the coronary artery bypass surgeries. The majority of these services are on the angioplasty side, not on the surgery. Every month through the cardiac network we post the amount of surgery that is done and the wait list management services. Generally speaking, in Ontario, we've met those targets.

Ms Martel: The Cardiac Care Network?

Mr Finkle: Yes.

Ms Martel: Can you give me the funding allocation over that period of time, either annually or cumulatively? What is the funding required to produce those additional procedures?

Mr Finkle: I don't have those off the top of my head, in terms of the amount of funding.

Ms Martel: I'm going to want the same, then, for the other commitments that were made, the 9,000 additional cataract surgeries, the funding.

Mr Finkle: Absolutely.

Ms Martel: And the same with the hip and knee replacements.

So you're saying, for example, with the cardiac surgery, that would be posted on the Cardiac Care Network, the additional ones that are done every month.

Mr Finkle: The additional surgeries that are done.

Ms Martel: OK. Is there a specific number you use as a base to start your work from to reach the 36,000?

Mr Finkle: It changes. We do get advice from the Cardiac Care Network, and the base has been changing for all of those services. We actually see, overall, a shrinkage in surgery and an increase in PCI, the percutaneous cardiac services—those are all the angioplasties. The interventional angioplasty services, the cardiac services are growing faster than the surgery, which we would expect as the change in technology occurs.

Ms Martel: The registry that will be in place by the fall of 2006 will be looking at all of those areas?

Hon Mr Smitherman: It will start by taking advantage of those registries which have already been developed, like CCO and CCN. We'll put up what we have and it will evolve over time in everyone's sight. But we'll start with those assets that are already developed.

Ms Martel: OK. Thank you.

Let me ask about the immunization program. You did confirm, Minister, that a significant portion of this money was the money that was announced federally. I thought the program was about $156 million. Is it $150 million, $156 million?

Hon Mr Smitherman: Over the three-year rollout of the program is the exact allocation we had from the federal government. I think it was $156 million over three years, but I'm going by memory.

Ms Martel: Is that what it is? So the first year it would be $50 million, then $50 million, and then the balance of $56 million in the third year, essentially?

Hon Mr Smitherman: Dr Basrur can give you more detail.

Dr Basrur: It's apportioned in roughly equal amounts over the three years, with an additional amount in the first year to provide for billings through OHIP for vaccinations.

Ms Martel: The concern I've had with this is, frankly, I have looked at the schedule and have seen there are children who are left out through the process. My concern was captured much better by a physician who wrote to the minister on August 30. I won't use his name, because I don't have that permission, but I'll essentially use the key point. He wrote to the minister to express his concerns about children being left out in the current schedule and said:

"Enclosed is a copy of a ministry bulletin from July 13, 2004, outlining the reasons for the introduction of your health care premium. In this, you indicated that monies collected would be used for expanding primary care, revitalizing public health and enhancing preventive health measures. As well, it is my understanding that the provinces were to receive funding for immunization from the federal government in their last budget. With these resources,"—he's meaning both the health care premium and the federal money—"I do not understand why you have decided to exclude this cohort of children. The loss of even one of the children in these two groups due to a preventable illness, when you are funding immunization in all other children as of January 2005, is reprehensible."

My concern is, it was stated very clearly that money from the health premium would be going to the immunization program. What is clear, I think, is it's essentially being funded with federal money, which is fine, but I would really encourage you, Minister, to have a second look at this, because there are children who are not covered—

Hon Mr Smitherman: There are—I'm sorry.

Ms Martel: —and won't be. So go ahead.

Hon Mr Smitherman: I read the letter, and I think—Dr Basrur can answer to this as well, but I've made my judgment on it. The judgment I've taken is that of course we have to design programs within the realm of what's available, and that's what has been done in this instance.

There is a panel, and Dr Basrur can tell us exactly what they're called, who have helped to profile and tell us the best way to develop a program. To suggest that there are cohorts left behind and the like I think misses the point, which is that at an appropriate opportunity, all of those children will gain benefit of those vaccinations. The program has been profiled in a way to provide the benefit of vaccination at a period when science best demonstrates that children be given that opportunity. I think we have constructed a program which absolutely makes sense. I offer no defence to the idea that, like many other areas of health care, were there a broader array of sums available, it would be one of those areas, of course, where perhaps it's practical to go further and further and further. In this instance, I think what we've designed is a program that really works for kids. I think Dr Basrur could give you more of the scientific basis for the decision points that were taken.

Ms Martel: Before she gets there, let me just say this: They weren't my ads, they were the government's ads that said very clearly that money from the health care premium would go to pay for the vaccination program. In truth, all of the money for this program is being paid by federal money.

Hon Mr Smitherman: No, not a truth.

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Ms Martel: Over the next three years, it certainly is. You just confirmed that for us.

Hon Mr Smitherman: Not at all, because I wasn't seeking to get into all the detail that acknowledges that there are costs borne, as an example, on the doctors' line of our government's budget and the like. There are certainly costs borne by those things that are supported by the health premium—way more important in terms of who provides the vaccination and what fees might be derived from that.

I think the point that's the essential one here is that the federal government did provide a limited amount of money in a limited amount of time for a vaccination program. The government of Ontario has made a commitment to maintain that program on an ongoing basis. That means, yes, of course, that's only made possible with the provision by Ontarians of the resources of the health premium. It's the kind of thing—

Ms Martel: But three years from now, Minister.

Hon Mr Smitherman: Immediately as it relates to some costs, but in terms of the ongoing sustainability of the program, it wouldn't be possible to contemplate without the additional resources that the health premium raises.

Ms Martel: Let me ask this question, then. You have said doctors' fees, their billings to OHIP for them to do the injection—"provide the shot" is what I'm guessing you're referring to: Can I have a breakdown between what that cost is and what the federal money is paying for? I'm assuming the federal money is paying for all of the vaccines. What other costs, then, Dr Basrur, please?

Dr Basrur: The federal money is paying for the vaccines and for administrative costs for both immunizations delivered by physicians, a small proportion, as well as any funds that are required by public health units to administer these vaccines.

May I just comment on the letter you mentioned previously?

Ms Martel: Just before you get there, can I ask, what is the balance that the province of Ontario would be paying? After the federal money pays for the vaccines and the administrative costs by physicians and public health units, what is the balance that the province would actually be paying for this program?

Dr Basrur: Well, in principle, the program rollout, the design, the communications plan etc would be covered by our public health division budget. So there would be a provincial component to that over and above the actual cost of the purchase of the vaccine products.

Ms Martel: Can I ask what it is? What is that share?

Dr Basrur: I could provide that detail to you. I don't have that figure off the top of my head.

Ms Martel: That would be great.

Hon Mr Smitherman: I make no argument that it starts small, but the sustainability of the program in the longer term depends upon the taxpayers of Ontario, the collection point of Finance Ontario. This is a program that will run forever; the federal funding runs out after three years. We've made a commitment that this will be added to the basic vaccination services of the government of Ontario, and it's clear that that's not possible without a health premium.

Ms Martel: I understand that. The point I'm making is that in trying to sell the health care premium to Ontar-

ians, the government ran a series of ads and those ads clearly said that the vaccine program was going to be paid through the premium. I think most people out there thought that meant right now.

Hon Mr Smitherman: On a point of order, Mr Chair: The member has just said that the government paid for ads, and that—

Interjection.

Ms Martel: The party? Pardon me. I apologize.

Hon Mr Smitherman: Those ads were paid for by our party.

Ms Martel: I apologize, Mr Chair.

The Chair: Don't confuse me with the Speaker and expect a ruling. Ms Martel, you have four more minutes left.

Ms Martel: The Liberal Party paid for ads to try and convince people that the premium was going to go to pay for new health care services. I think in fairness—right?—the ads certainly didn't say, "By the way, your portion of this for the vaccination program will start three years from now." The ads were put out in a way to make people think that right now, here and now, as they get their premium dollars taken off their cheques starting July 1, that's somehow going to pay for the vaccination program, and that's not really the case.

Anyway, if you could respond with respect to the letter, that would be great.

Dr Basrur: We based the original program design on the recommendations of the National Advisory Committee on Immunization to reflect the epidemiology of these diseases in the childhood population. We have recognized, through our consultation with medical officers of health and community physicians, that there has been a concern expressed about the original eligibility criteria, such that children who were one year of age would get the shot but if they were a day past their first year, they would be ineligible. We are reviewing that restriction so that we don't have kids who are, on a technicality, made ineligible for a vaccine from which they could benefit.

Ms Martel: Can I ask, then: Does that mean that there will be a change in the eligibility criteria that will cover more of the children? When would I expect that to go into effect?

Dr Basrur: That is currently under an active review within the ministry. We're in discussion, as I mentioned, with local medical officers of health and with others within the decision-making process. I hope that it will be communicated as quickly as possible to lay to rest any concerns on the part of parents or doctors that kids aren't going to get this benefit.

Ms Martel: OK. I appreciate that very much.

Can I ask one question with respect to primary care reform? I'm just curious: Where do CHCs fit into this?

Hon Mr Smitherman: Community health centres fit into this in two or three ways. First, I always say that family health teams find their ideological roots in the interdisciplinary model of practising community health centres. I signed letters yesterday. I know that those letters will land and no one will pay any attention until they only open the cheques.

Ms Martel: Depending on what community you're talking about, that may be the case.

Hon Mr Smitherman: Community health centres are about to receive a letter with a very significant, substantial increase in their base operating.

Ms Martel: Is that to all?

Hon Mr Smitherman: Yes. I'm going by memory here, but I think that's 7%. It's in the 6% to 7% range. In addition to that, we will shortly—and I mean, within a matter of weeks—be in a position to announce an expansion of satellites from existing community health centres to service additional communities in Ontario.

Ms Martel: This is the 10 that you referred to in your speech yesterday?

Hon Mr Smitherman: Yes, that's right.

I would just say this to the member—and I'm well practised on this because there's a lot of supporters of CHCs around, and I'm one of them; I have the benefit of three of them in my riding—it's a model that was designed to be particularly applied in communities that had really serious underlying population health challenges. We think that with the family health teams moving forward, CHCs will be able to revert to that role. We'll be able to consider them as a deployment opportunity in those particular instances.

As you well know, over the past number of years, while there has been this ongoing and worsening problem of access to family physicians, communities all over Ontario have reached out to community health centres as the thing they try to grasp in getting care for their communities.

I just want to make this point: All of those communities which have applied for community health centres are going to be in the first crop of communities given an opportunity to apply for the first tranche of family health teams. We're going to make sure that the data that they've used already in preparing for their CHC applications is also data that can be utilized in the family health teams application process. So what we're trying to do is give those communities which have already invested a lot of their heart and soul in the development of those plans an opportunity to compete for the first tranche of family health teams.

Ms Martel: But in the first 45 that will be announced, there will be CHCs that have been on a list, either to expand or to create new ones?

Hon Mr Smitherman: No, well, they won't be CHCs. What I mean to say is that these will be family health teams, but of all those communities—I think it's between 80 and 100 that have applied for CHCs—we're going to give them the first shot at family health teams, because family health teams will address many of the problems that have motivated them to seek community health centres.

Interjection.

Hon Mr Smitherman: Yes. They are, by their nature, less comprehensive than a community health centre.

The Chair: Ms Di Cocco, are there any members of the government—

Ms Di Cocco: No. We'll waive our time.

The Chair: All right. Then, Minister—

Hon Mr Smitherman: Can I take their time?

The Chair: Well, when did you need another break?

Hon Mr Smitherman: Right after my scrum.

The Chair: Do you know, actually, I should make up eight minutes, but I can't figure out how to put that on Hansard, so I won't. So please, Minister, sum up.

Hon Mr Smitherman: I just want to say thank you. Yesterday, I began this process—in the first few paragraphs of my remarks I used the word "trepidation." It's proven that that was an appropriate sense to have. I've enjoyed this immensely. I appreciate the level of detail and awareness that people have about what is a very substantial piece of government program, one that I'm very honoured to have the opportunity to deliver.

I think that we've had the chance over the last seven and a half hours to make a very strong case about our government's plan for the future of health care in this province. It's a plan that has a measurable destination point. It will be measured by more access to family physicians in local communities, more progress, and addressing the challenges of wait times. It will be measured by the underlying population health of our citizens and it will be measured on our capacity to deliver health care in this province in a fashion which is sustainable for future generations.

We're doing that through a coordinated, comprehensive strategy to drive care down to the community level, to make it available more upstream, because we believe that the best health care is the health care that you find as close to home as possible.

We will make progress on all of these files because the health care system in Ontario is driven by something like a couple of hundred thousand people who are very dedicated every single day to providing care to people needing it in all communities across the province.

We'll build on the strength of our health human resources. We're going to rally the troops to create an actual health care system, and in so doing, I think we're going to demonstrate to ourselves that, even though we're doing a great job already and a lot of extraordinary care is provided every day, and a lot of miracles too, we can do better in this province than we have so far at integrating the services so that the patients receive services in a fashion which is better coordinated.

I want to say what I said right from the top, which is thank you, Mr Chair, to you for your role here, to all members of the committee, and especially to the Premier who gives me the opportunity and honour every day to fulfill this very exciting portfolio.

The Chair: Thank you very much, Minister. On behalf of the committee, I'd like to thank all of your hard-working staff, who have been here with us for two days to respond to questions and to do so in such a professional manner. We appreciate that.

Hon Mr Smitherman: We're grateful.

The Chair: Given that at this point it is deemed that we have reached the allocated time in which to handle the estimates of the Ministry of Health and Long-Term Care, I am now called to take the stacked votes in order.

Shall vote 1401 carry? All those in favour? All those opposed? It's carried.

Shall vote 1402 carry? All those in favour? Opposed, if any? It's carried.

Shall vote 1403 carry? All those in favour? Those opposed, if any? Carried.

Shall vote 1405 carry? All those in favour? Opposed, if any? It is deemed carried.

Shall vote 1406 carry? All those in favour? Any opposed? It's declared carried.

Shall vote 1407 carry? All those in favour? Opposed, if any? That is carried.

Shall vote 1408 carry? All those in favour? Opposed, if any? That's carried.

Shall vote 1409 carry? All those in favour? Opposed, if any? It is carried.

Shall the estimates of the Ministry of Health and Long-Term Care carry? All those in favour? Any opposed? That is carried.

Shall I report the estimates of the Ministry of Health and Long-Term Care to the House? All those in favour? Opposed, if any? That is carried.

The standing committee on estimates stands adjourned until 9 o'clock tomorrow morning, at which time we will welcome the Minister of Energy to begin those estimates, for seven and a half hours.

The committee adjourned at 1504.

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