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Wednesday 28 September 2005

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Mercredi 28 septembre 2005

Standing committee on estimates

Ministry of Health
and Long-Term Care

Ministry of Children
and Youth Services

Comité permanent des budgets des dépenses

Ministère de la Santé
et des Soins de longue durée

Ministère des Services à l'enfance
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STANDING COMMITTEE ON ESTIMATES

COMITÉ PERMANENT DES BUDGETS DES DÉPENSES

Wednesday 28 September 2005

Mercredi 28 septembre 2005

The committee met at 0859 in room 151.

MINISTRY OF HEALTH AND LONG-TERM CARE

The Chair (Mr. Cameron Jackson): Good morning, ladies and gentlemen. I'm pleased to call to order the standing committee on estimates. We welcome the Honourable George Smitherman, Minister of Health and Long-Term Care, and his outstanding deputy, Ron Sapsford.

Interjections.

The Chair: For the record.

Ms. Shelley Martel (Nickel Belt): I think you're being set up, Ron.

The Chair: No, not really.

I'm going to exercise a prerogative of the Chair. I'm going to change the rotation. We have completed five hours. We have three hours remaining. It is our intention to be done today by 12 o'clock. We will need four or five minutes prior to 12 in order to pass the votes, but since I need to vacate the chair in order to ask some questions, Ms. Martel has graciously agreed to begin her 20 minutes. It will then revert to the official opposition and then to the government.

If there's no problem with that, we'll proceed. Ms. Martel, you have the floor.

Ms. Martel: Thanks, Mr. Chair. Minister, I want to just return to the line of questioning I was on when we ended yesterday, and that had to do with me raising a concern about information brought to my attention by SEIU with respect to bathing regulations.

Just to be clear, the reason I raise it with you is, I am concerned that there are some owner-operators who are essentially undermining the spirit and intent of the regulation. It's not an issue of trying to accommodate the concerns of some residents who may say that they don't want to have two baths a week; it is a situation where operators, owners of homes, are directing staff to essentially provide bathing by way of a damp washcloth versus a real bath and that they're being ordered to do that. I think that's a much different thing than trying to find an accommodation with a resident who really doesn't want two baths a week.

I raise it with you in the hope that during some of the unannounced inspections that ministry staff are involved in, some questions will be raised with the staff and owner-operators and indeed with residents about what is happening in this regard. The regulation was passed. I don't think any of us want to see it undermined, and that was the context within which I raised it yesterday. So I hope that some information/direction can be given to inspectors to have a look for this when they are next doing unannounced inspections in homes.

Hon. George Smitherman (Minister of Health and Long-Term Care): We're happy to take that advice, but I would just say as well that if it's the desire—yesterday, I said that we have worked pretty hard to enhance our compliance capacities to streamline those processes and to be able to ensure that calls that come into the hotline are followed up on. We're taking that bit very, very seriously. We'll certainly take a good look at what we do as relates to unannounced inspections, but as you've raised a particular case, it would be our instinct—the deputy would send that one through the system, if you will, and get them to take a look at it more particularly.

As I had a bit of a chance to say yesterday, some among that frail population are not enjoying the idea of two baths a week and some of them are preferring other modes that would provide for their needs. This I've heard from them first-hand, but as you've raised one that is rather specific, we'd like to send it through our system and get people to go in and take a look at it. Why wait for an unannounced inspection? We have capacity now. Let's take advantage of the concern that's been raised and go and take a look at it.

I'm not sure if the deputy has any more on that.

Mr. Ron Sapsford: No. Just after the session, perhaps if I could get the information, I'll follow up on it.

Ms. Martel: That would be great. I've heard it at a CUPE conference as well that I spoke at two weeks ago. So it came from both SEIU workers and CUPE workers. It would include a fair range of homes, actually.

I want to go to recommendations that came from the Casa Verde inquiry. The coroner's jury and those recommendations were released, I believe, in April—about 85 recommendations made with respect to a very tragic circumstance in a home in Ontario where a resident was responsible for the death of another resident. I want to know what the ministry's public response is to the recommendations. It was a lengthy inquiry. A broad range of issues was canvassed and some very significant recommendations were made in terms of staffing, funding, changes and training. Is the ministry going to be

publicly responding to the recommendations, and can I ask when that will happen?

Hon. Mr. Smitherman: The ministry response will be reflected in the long-term-care legislation. I know that you've been critical at times of the delay in bringing that legislation forward, but it was in fact in part measure having this Casa Verde inquest coming with a significant degree of recommendations that we thought it was very appropriate to make sure we gave those an opportunity to influence the development and presentation of a bill on long-term care.

I think that in terms of the response to those recommendations from the inquest, the long-term-care legislation, which will be forthcoming this fall, is the place to look for influence. I'm not sure, Deputy, if there's anything you want to add to that.

Mr. Sapsford: Yes. We have followed up on a number of the recommendations, particularly in the area of training and education, and new training programs are being developed for staff in long-term-care homes to better handle this kind of resident. The more difficult recommendations were with respect to creating specialized units, and that's a piece of work that is going to take a bit longer. But staff are looking at the policy implications of that: how those kinds of units would be implemented, what the cost implications of those would be. So that's a piece of work that is still ongoing and will take a little bit longer to come to a conclusion.

Ms. Martel: OK. Just so I'm very clear, Minister, you said the response will essentially be seen in the development of the long-term-care legislation or the final outcome, and, Deputy, that you're looking at the specialized units. Is it your intention to have a more formal—"announcement" is probably not the word I'm looking for—response to indicate these are the recommendations that have made their way into the bill, these are the pieces that are outside that are policy changes we intend to move on? Is it your intention to respond in that way?

Mr. Sapsford: There was no plan to have a separate formal response to the recommendations at this moment.

Ms. Martel: You know what? I would just encourage the ministry to consider that. It was a very important inquest. It had a significant degree of union involvement in terms of workers on the front lines who have concerns. I think if the ministry is looking at responding fully and significantly to the recommendations, it would be a good idea for you to actually do it that way. It would clearly show that you're responding. I think that would be positive for the ministry.

Let me ask one final thing in this area, and that is about the classification model. Is the ministry considering a new classification model for standards of care, and if so, when it might be implemented and how it will affect the funding envelopes?

Mr. Sapsford: The answer is yes, we are looking at a new classification system. The current system was based on the Alberta model, which has been used for quite a number of years. The evaluation tool was focused almost exclusively on nursing. In long-term-care homes, there are many other factors to take into consideration as one weighs the requirements for resources.

We've been working on a new tool. I think the letters are MDS. I'm not sure what that means, but it's a much more extensive monitoring tool to measure all areas of the patient care environment, the resident environment. It's a more complicated tool technically; it requires more data to be collected and analyzed. We're in the process of working through the details of the data and trying to track the results of that information to outcome standards. At the same time, in the compliance system, we're looking at a much more specific enumeration of the outcomes of care that we're looking for so that compliance inspections in the future can focus more on outcomes than process in the home as care is provided.

So those are the two major activities that we're undertaking now. I hope that before the end of this fiscal year we'll be in a position to conclude whether or not we're moving to the new tool and will have had, by that time, an ability to assess the impact on resource requirements and how that information would affect the current funding tool.

Ms. Martel: And there may be an implication on training of staff?

Mr. Sapsford: Yes, there may be.

Ms. Martel: And so the minister will have to consider how that's funded.

Mr. Sapsford: Correct.

Ms. Martel: Very good. Thank you.

I have some questions about proxy pay equity that come from the estimates book. I'm just trying to be clear on the employers that are affected in the sector. The first question I have is on page 127. It's the indication of $28 million for proxy pay equity. It looks like it's coming out of both the long-term care side and community-based programs. Assuming that the employers covered would be those in the long-term care sector, are there any others we should know about? I'm not sure who's the best person to answer.

0910

Mr. Sapsford: I believe it's mostly in the long-term-care sector. I believe some of it as well is in the community health sector.

Ms. Martel: So community-based mental health agencies or community—

Mr. Sapsford: I can get you the specifics. I don't know specifically which agencies. Any that had negotiated agreements are represented in the number.

Ms. Martel: Can I just give you some other questions that run from there? Then, when you can get some responses for me, that would be great. It doesn't have to be right now.

The other place where I saw it identified is on page 107. It's a $53-million proxy pay equity. Again, if I could just be clear on the employers that are involved, and if I've missed any—I think I got both sets where I saw "proxy," but is there any other section in the estimates where proxy is noted? If you could just give me the total proxy pay equity that was paid by the ministry, I'd like to

get it over some past periods, if you don't mind: 2003-04 and 2004-05, for the same sectors that I referenced in these estimates, please.

Mr. Sapsford: OK.

Ms. Martel: Great.

I wanted to ask some questions about home care. I know Mrs. Witmer asked if money had flowed to CCACs, and I had seen that announcement in my own riding, so I know that had taken place. I had questions about changes in home care regulations, because one of the promises that was made was to change regulations that had been put in place by the Conservatives which essentially limited home care hours for clients, even if they might require more, particularly for special needs children and special needs adults; secondly, the requirement that you had to have a basic personal care need it order to get homemaking services, which is certainly in effect in our part of the world.

I would like to know if there have been regulations made under home care that would eliminate that restriction on home care hours, and secondly, eliminate the condition that in many CCACs you have to have a basic personal care need before you can get homemaking services.

Hon. Mr. Smitherman: I think that on this one, we had the opportunity at the moment, through the review we're doing of the recommendations that came forward from former health minister Elinor Caplan, to take a look at these other regs. We have some limitation on the resources that are being put into home care as they relate more specifically to the health accord federally. I'm not sure whether that might constrain progress on these regs, but that would be the place we would be looking at, that we would bring forward any necessary reforms all at the same time. So we would be reviewing those regs in that context.

Ms. Martel: I'd make a pitch for changes in both, particularly to end any restrictions that might be in place to offer homemaking services to people unless they have a basic care need. There are many seniors I know who don't have a basic personal health need that has to be met but who could sure use a lot of help with laundry etc. in order to stay in their own homes.

Hon. Mr. Smitherman: Just on that point, yesterday I attempted to make a point—maybe I didn't do it well. I do acknowledge that sometimes it's hard to know how to characterize that, because over time the basket of services in home care has evolved quite a lot, to focus, I think especially because of federal dollars, on post-acute; in other words, the focus on trying to shorten hospital stays or keep people out of the hospital. Accordingly, I think some of those easiest to provide and most necessary for seniors, those services that support them for what I referred to yesterday as "aging in place," have been diminished.

In other parts of the ministry, though, we've worked to marshal $25 million in each of the last two fiscal years to enhance the quality of the kinds of supports that you're speaking about. Yesterday I referred to Meals on Wheels as an example of that, and also drives to appointments, which many of the community-based organizations—like SPRINT here in Toronto, as an example, or Mid-Toronto Community Services in my own riding—are very involved in.

There are lots of areas—I've had a chance over the last five hours and a bit to talk about where we would all acknowledge it would be better to have more resources, but I think this is one where I'm happy and proud that we've been able to put some additional resources into what I call community support services.

I understand exactly where you're coming from in terms of the regulation—this is something that we can take a look at—but I just wanted to make sure that you knew that we had dedicated in each of the last two years $27.5 million, I believe, in 2004-05, and $25 million this year, to enhance those community support services. The ministry is operating on the expectation that in each of the next years, we will continue also to build on those community support services.

I'm not pretending that we're meeting needs. Obviously, those needs are growing quite considerably, and this is one of those areas where dedication of additional resources would be very beneficial. In that context, we can also take a look at the regulation and see if that would be helpful in the piece. So I'd be happy to do that.

Ms. Martel: There will be some added fiscal implications for the ministry, obviously, if you made that change. On the other hand, what you see happening, at least in my own riding, is people who got cut off two years ago now having to go into a long-term-care home, when really, with a little bit of support for laundry services, for homemaking, they would be able to be maintained in their own homes. In terms of the cost of a system, it's a whole lot more.

Hon. Mr. Smitherman: I wouldn't want to prejudge an outcome. We'll take a good, hard look at it, but we should be operating on the assumption that if we were to make a regulation change that might necessitate an adjustment within existing fiscal resources—I just don't want to pretend that I'm going to be in a position, necessarily, to be able to change a regulation and accordingly expand the amount of resource available. It may be that a regulatory change would have the effect of redistributing some of the resource.

It's important to note that we are continuing to make investments in home care and we are going to continue with that path. It's one of the most essential things that we can do. So that may give us some additional opportunity to consider the reg. change that you're recommending. Anyway, more to follow, but I get where you're coming from and I agree that this is an area where we could and need to do better.

Ms. Martel: When will you be responding formally to the Caplan report?

Hon. Mr. Smitherman: I must tell you that we probably have a date around that. I suspect that the best answer is the fall, but I'll be entirely forthright in telling you that my major briefing on this—in other words, the response to this—I think is tomorrow. In other words,

I'm still somewhat at the early end in the ministry context of reviewing and giving direction and moving forward on the recommendations. So I'd say we're targeting the fall, but I would just reserve the right to tell you that, because there are a number of things going on across the street, I can't promise exactly when we will be moving forward publicly on that. It is under our active consideration, starting with a briefing that comes either tomorrow or Thursday—tomorrow is Thursday, so I think it must be tomorrow.

Ms. Martel: One final question on home care: Your colleague Ms. Pupatello had a great deal to say about Bill 130 when we were in opposition, and Bill 130 of course remains in place, which set in motion some really direct control by the ministry over CCACs. It was certainly a promise by both of our parties that we would repeal that because of the enormous ministry control over some of these, which should be community-based agencies. Is your government going to repeal that legislation?

Hon. Mr. Smitherman: I'm not going to respond directly to your use of the word "repeal" of that legislation, but I will say this: We continue to support the idea that community care access centres, that the provision of home care services, should be a community-governed asset. You'll see our government's intention to move forward in that capacity coming forward.

Ms. Martel: I think "repeal" was the word she used, but that's all right.

Hon. Mr. Smitherman: I don't doubt it.

Ms. Martel: I don't think; I know.

Hon. Mr. Smitherman: I'm just not sure that, in the way we will respond to this, "repeal" is the word we'll use. But in terms of the intent of restoring community governance over community care access centres, this is something that our government continues to support, and you'll see progress on that forthcoming.

Ms. Martel: A couple of questions in the community health sector: Has the money that was announced for community-based agencies gone out to them?

Hon. Mr. Smitherman: Yes. We worked very hard this year, in almost all instances—

Ms. Martel: Before we got here.

0920

Hon. Mr. Smitherman: No, not just before we got here, but we actually were working on a view, each year, to try and improve how quickly we flow dough. Most of it we tried to get out the door by June, which for the Ministry of Health is pretty fast. I'm pretty sure that's one of those where we met that test. So, yes.

Ms. Martel: Can I ask, what does the increase represent in terms of percentage to the base? Do you have it broken down in that way?

Hon. Mr. Smitherman: I think it was 1.5%.

Ms. Martel: In terms of being 1.5%, does that deal with the pressures that community-based agencies were still facing trying to maintain their existing programs and to deal with their waiting lists?

Hon. Mr. Smitherman: What it does is it gives them a continued path of additional resources each year, albeit at a rate that no one would pretend gives them a tremendous amount of capacity to expand programs. If we look at the record of provision of government resources to these sorts of programs over the past 10 or 15 years, they have not enjoyed a consistent contribution from the government. It was on again, off again. What we seek to do, even in an instance where our fiscal resource is quite limited, is continue to maintain our commitments across the breadth of health care sectors so that nobody gets back in the position of losing considerable ground. We use an example very often, and I used it again yesterday, of community mental health, where we saw no increase I think from 1992 or 1993 through almost 2003—for 10, 11, or 12 years. It's a modest amount—no one's arguing otherwise—but it is designed to recognize that we as a government are committed to these services, and accordingly we're going to make sure that, even in tight fiscal circumstances, they aren't allowed to slip back.

The Vice-Chair (Mr. John O'Toole): Thank you very much, Minister. That concludes that time.

We'll now move to the official opposition. The Chair recognizes Cam Jackson.

Mr. Cameron Jackson (Burlington): Thank you, Mr. Chairman.

Minister, in this 20-minute segment I would like to pursue issues with respect to the Ontario drug benefit plan with section 8 drugs. I wondered if whichever staff member responsible for that is here, so I could ask some specific numeric questions.

Hon. Mr. Smitherman: If you want to ask the questions, the deputy now will take a stab at them, and then we'll see what help we need.

Mr. Jackson: It's my understanding that about 75% to 77% of all applications for section 8 are approved. Is that true, according to the recent report, and what is it that we're spending on section 8 in this province?

Hon. Mr. Smitherman: We can bring some of that information forward. I would just want to give the member a little bit of context on the issue of section 8—

Mr. Jackson: My question isn't about section 8, Minister. I was just wanting to determine the amount of money within the ODB budget that is devoted to section 8s.

Hon. Mr. Smitherman: In your first question, you didn't ask about the amount of money, so I will take a look at it. Do you have those numbers, deputy?

Mr. Sapsford: Yes. With respect to the percentage of approved: In 2002-03, it was at the rate of 75%, and in 2003-04, it was 72%. It varies year to year, but it's usually in the 70% to 75% range.

Mr. Jackson: And the amount of money that that represents? The only number I have is that the top 10 drugs amount to about $93 million.

Mr. Sapsford: I'll find that number for you.

Mr. Jackson: Thank you.

Minister, I'm trying to understand why we have section 8 coverage for oral medications, including cancer-based oral medications, but we do not have a policy or an access point for Ontario patients for intravenous-ad-

ministered drugs that are outside of the ODB or outside of coverage. In other words, Minister, we seem not to have a section 8 kind of access point for patients in Ontario simply because the medications they seek are administered intravenously.

Hon. Mr. Smitherman: I'll allow the deputy to offer some view on this as well. The context that I wanted to give the honourable member just a second ago—because we talked just a tiny bit yesterday about some of the work that we've got going on back at the ministry. We've created a drug secretariat headed by Helen Stevenson, and we've been working very hard internally on a variety of initiatives that we're gathering to come forward within a period of the next three to six months.

Part and parcel of the mandate that she has been given is to take a good, hard look at the entire section 8 situation. You know this stuff very well. This, which I think started—my numbers may be slightly wobbly here, but they'll be pretty close in orders of magnitude. When section 8s began in 1995 or something like that, there were 5,000 or 6,000 of them. Last year there were, I think, close to 150,000 of them. I think that's a pretty sure sign that a program that was intended with one set of conditions or what have you has evolved to be something different.

So I wanted to work to give you the best answer that's available at the moment. Just to let the honourable member know, one of the things that I'm very, very keen to be able to do is to remove the burden associated with section 8 from doctors and from patients to the greatest extent possible. I think it is possible, in an environment with appropriate prescribing guidelines and the like, to give more responsibility and onus to clinicians to be prescribing appropriately and therefore to remove some of the administrative burden.

Deputy, did you have anything more specific to the question?

Mr. Sapsford: Your characterization of intravenous drugs, I think, is the point that you're raising. Typically, intravenous drugs are administered in hospital, and as technology changes, we're more and more able to administer these drugs in outpatient and non-hospital settings. So I think the difference is between the drugs that are administered in hospital or in formal cancer clinics versus ones that are able to be administered on an outpatient basis.

Mr. Jackson: That brings me to the concern I have. You have established, and I have raised the issue, that we have a gap here in our system where cancer clinics have no mechanism by which they can approach the Ministry of Health to have coverage for certain of these drugs.

The drug I want to raise with you today is Velcade, which is a relatively new drug of the last two years with a very successful pathology attached to it. It is for persons with multiple myeloma, which is a cancerous condition that attacks bone marrow cells.

I have four constituents who are currently queued up and seeking financial assistance with this very costly medication. I've spoken to George Petrunas rather extensively, and I wish to quote from a note that he has shared with me that sums up some of his concerns:

"[M]y immediate priority is to acquire Velcade, which is an intravenous-administered chemotherapy drug used for battling multiple myeloma, a bone marrow cancer.

"Velcade may give me an extension to my life as my protein levels are rising unchecked.

"Princess Margaret Hospital (and Joseph Brant Memorial Hospital) does not have the funding to administer this medication for me or other patients.

"The only means for me to access Velcade now is to acquire it via the private clinic Provis and pay for this medication out of my own pocket.

"I received an invoice and one cycle will cost over $10,000 with payment requested up front. Up to six cycles may be required."

He quotes from Douglas Emerson, a very interesting individual and again a constituent of mine, who was successful in acquiring Velcade from this government.

Doug Emerson, in his article, identifies a couple of issues. First: "The ministry's hospitals branch, headed by branch director Peter Finkle, commented there is a gap in the system that prevents a patient from applying for emergency access to an IV drug under review for funding." Secondly, "There also is a panel of experts, the Drug Quality and Therapeutic Committee, that reviews the eligibility of drugs for funding. Velcade has been under review since February by this subcommittee, which reports to the drug programs branch of the ministry.

"Policy changes are best addressed by the Ontario Hospital Association and other boards...." He goes on to say that he doesn't have the clout.

He closes by saying, "I have to deal with an immediate human need to prolong my life." So he is focusing on his care. He has asked myself and others to approach the government with a series of questions as to why this condition exists.

So, Minister, I guess my first question is: Why is it taking so long for the drug therapeutics branch to do the review of Velcade when it has been approved and is being paid for in three provinces? It is approved and available on a section 8 kind of format in the remaining provinces. Why is Ontario still not able to approve Velcade for funding? I don't think its medical analysis is questioned here. I think much of this has to do with its financial implications for Ontario. I've raised a lot of questions, but I suspect the minister understands this issue very clearly.

0930

Hon. Mr. Smitherman: I think there are two or three things that are really important to reference. Obviously, any time we're dealing on a constituent basis with someone who sees a product that is on the market somewhere in our global environment, boundaries and jurisdictions are sometimes eviscerated by technology. But I think that we must recognize that in an environment where new drug product, and perhaps more particularly new cancer product, is going to be made available on an almost daily

basis, so it seems, we have an obligation to ensure that we're acting in an evidence-based fashion. Accordingly, we rely on the DQTC to give us advice around that. They have been actively reviewing Velcade, to the point where they have requested some additional information a couple of times from the company.

I can tell the honourable member that over the course of the last while, we have sought to enhance Ontario's provision of necessary cancer drugs. This has caused a more than doubling of our new cancer drug budget. We're going to continue to use evidence-based processes to help determine which products have appropriate efficacy so as to be able to make them part of our arsenal, if you will, in assisting our patients in Ontario in battling cancer. Velcade stands amongst those.

As for other jurisdictions, you'll see, on a case-by-case basis, that different jurisdictions are able to treat different product in different ways. We have a reliance here on the evidence-based, through the DQTC, and that work is ongoing.

Mr. Jackson: With all due respect, Minister, the point I'm raising here is one of time. I've never challenged the efficacy of the DQTC. I have, however, on many occasions challenged the length of time that it's taken them to arrive at a decision. You and I went through this process a year ago when I pursued a series of questions on the floor of the Legislature for a cancer drug involving a significant number of Ontario residents. What I want to stress to you is that this drug has been approved all across Canada, but we still, even if we approve it, have a gap between the Ministry of Health hospitals branch and the ODB, because we've got people—your own Mr. Peter Finkle has indicated that this is a gap in the system. So it really does come down to the costs associated with this drug.

Doug Emerson, in his extensive letters to some of us in public life, seeking our support, has referenced this. He says the following:

"The results of treatment"—of Velcade—"are that for the 35% of patients who respond well, the drug can prolong their life by a year or two.

"In other words, the province is trying to figure out whether a year or two of life is worth $40,000. As a general guideline, the province uses a benchmark of $50,000 per quality assisted life-year (QALY) as the measuring stick by which drugs are included or excluded. Why that benchmark does not appear to have been applied to this review remains a mystery...."

Mr. Emerson's research has brought him to raise this significant question because he has been tracking the DQTC's approval of drugs and their cost implications to the ministry. You have appointed Helen Stevenson, and we anxiously await her work. But it's our understanding that she is just, at this moment, drafting the consultation guidelines that will be released. Her report won't be released in three or four months, to be fair, Minister, and I'm not being critical of that; it's important that she does this. In the 21 years I've been here, I've seen four or five reviews of the drug program, so I want to make sure that you're given sufficient time to do it right. But I do not want to see Velcade held in abeyance while we wait for Helen Stevenson's input, or for the DQTC to be looking at the cost implications of this drug.

The drug has a high efficacy rate to it. Incidentally, this drug was discovered by a Canadian. All the trials were done in the US. They took palliative care patients, people who were at the end stages of this disease, and the recovery rate was as high as 12%—that's complete recovery. So this is a very powerful, significant new cancer drug on the market, which every other province has allowed their citizens access to, and yet we have created these gaps and impediments. With all due respect, Minister, you are in a position to accelerate the research and the work being done by the DQTC. You did that last year when you and I were locked in a debate about a drug for non-Hodgkin's lymphoma. So could you please respond to the questions raised by Doug Emerson with respect to the quality-assisted life-year benchmark, and why it's not being followed with this drug.

Hon. Mr. Smitherman: I can't refer to all of what you put in the record there because some of it was quite speculative and some of it was attributing language to a product around which I depend on evidence and science-based analysis. I think I need to make that distinction. The deputy may have some words to offer to follow up.

I take the member's essential point, which I think is related to timing on Velcade. The challenge that we're at, or that the DQTC is experiencing with Velcade, is that they have in their review asked for additional information from the company that has not been forthcoming in as timely a manner as might have been helpful. So we can continue to impress upon people the urgency associated with this, which ought to be apparent, but I understand that some of their challenge has been in receiving the information that they've requested from the company in a timely way.

For my part, I very rarely get myself involved in characterizations of benefits associated with drug product, because sometimes in the effort to sell, if you will, to encourage the support for a product, we run the risk, it seems to me, of eliminating the appropriate balance of science and the evidence-based element of it, where we have the capacity to measure consistently. I know that in a circumstance where a product that is out in the marketplace somewhere might look like it offers some level of benefit or hope to me and I'm in a situation where I need some source of hope, I'm going to want such a product. But of course, we have an obligation to make sure that these decisions are evidence-based, because the amount of product that is available, some of which is quite often of marginal benefit, is a real challenge for a publicly funded health care system. I'm not sure if there are other points that the deputy might wish to address.

Mr. Jackson: Minister, for the record, the science around this drug—Dr. Adams at McGill University received the Nobel Prize for his work in this drug.

I want to set aside the science. That is not the issue here. The issue here is whether the state is willing to pay

for a drug with as high an efficacy rate in other jurisdictions—maybe Ontarians won't respond to cancer treatment as well as our fellow Canadians in other provinces, but the truth is, it has about a 35% efficacy rate in terms of abating the progress of this disease. There are remission rates attached to this. For the record, this is a drug that has been used extensively across Canada and throughout the United States, and there is a wide body. I have on many occasions experienced the rebuttal from all manner of governments in the past with respect to the issue of still waiting for additional information. This is a system that can frustrate itself to an economic conclusion. That, in my view, is inappropriate.

My time is almost up, and I do want to raise one question, and this is a practice that is now occurring in our province. As you know, there are private cancer clinics operating in Toronto; Provis is one of them.

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Hon. Mr. Smitherman: Where are the others?

Mr. Jackson: That's the one that I'm aware of.

Hon. Mr. Smitherman: You said there were others.

Mr. Jackson: There are private clinics operating in Ontario, like Provis, which is a cancer clinic. There are private clinics.

Having said that, there are cases that have been brought to my attention where people are going into a pharmacy and buying the drug Velcade, and then going into hospitals and having the drug administered. My understanding is that that is not legal under the Canada Health Act. I would ask you if you've had a chance to put your mind around that issue and if you're going to address that. I think it is part of this larger issue of the gap in getting our hospitals to come up with a program. Some hospitals are not turning away cancer patients who come with this intravenous medication but allow it to be administered in a clean, safe oncologist-supervised environment. I'll leave you with that question and you may wish to respond. But to my knowledge, if that is going on, that's an added reason why we should be responding to this particular drug at this time.

The Vice-Chair: Thank you. We've run out of time. If the minister would like to respond as part of a future question, that would be great. From that, we will move now to the government side.

Ms. Caroline Di Cocco (Sarnia–Lambton): Minister, the topic I'd like to broach has to do with my interest as a mother, and now as a grandmother. The world of newborns is something that I certainly lived for a number of years. We've come a long way from the time, for instance, of my mother's era, when she had very little medical attention when it came to the care of newborns, and then from my days when I took care of my children, and now, with this wonderful world that I live in as a grandmother of two very small children. I've always been interested in the inroads that we've made with the miracle, for instance, of premature babies and other areas of medical science when it comes to newborns.

For me, the whole topic of newborn screening has always been something that I've watched very carefully, seeing how we've progressed. Even when I was in opposition, it was something I certainly noted. I watched with interest when one of our colleagues—I think it was Dwight Duncan—brought forward a private member's bill that would enhance the province's newborn screening program.

I go to the core: Newborns can't lobby. With the previous government, it always astounded me when I saw that there was very little attention. We lived in an era that really was not about building programs in a way that would enhance some of these areas. I know this is a very specific area. I know it has come up again in the media and certainly in discussions.

I know there's so much that has to be done in health care, and there are a lot of competing issues all the time. In this area, what we've inherited certainly wasn't ideal when it comes to this specific sector of newborn screening. I would like to know what progress we've made in upgrading newborn screening.

Hon. Mr. Smitherman: I want to thank the honourable member for the question, astonished as I am to hear that she's a grandmother. You just keep getting younger.

A few things on this: Yesterday we had an interim report, I think, from the Ombudsman on the issue of newborn screening. The report gives all of us who are legislators some opportunity to reflect on this issue. I think it's fair to characterize it as an opportunity missed for quite a long time and an opportunity now being seized upon.

There are partisan points to be made, if people choose to make the debate that way. I would just say, as I did yesterday on another item—I can't remember the topic—that some of the circumstances we have are the inherited capacity of our health care system that we all own. If there was a committee going on and I was at the committee, I'd be taking a partisan angle, because I'd say, "Nice of you now, John Baird, to catch wind of the interest in this issue, but you just came off being government for eight and a half years, when all of the same progress that we are now making was possible."

These issues have been around for a long time. It doesn't stand out as part of the collected, inherited institutional capacity—I don't think these are the best words—of the Ontario health care system. What we inherited was a circumstance where Ontario was in last place in terms of taking advantage of all the technology offered to test newborns, to screen newborns against a series of things. Blood disorders are one of those, as an example, where we still have more progress to be made.

Here's where we're at. First, I make this commitment on behalf of the government of Ontario, and it's one I repeated to my Premier yesterday: We will take Ontario from worst to first. We have already made a big leap forward in terms of the decisions we've made to go from testing for two diseases to 21. We've already made that leap forward. That will require some period of implementation. We have to buy tandem mass spectrometry machines. We have to have them installed, and because the nature of the calibration of these machines is so

precise, the ramp-up is not as immediate as anybody would prefer. But the message must be sent from this place, because it seems like it hasn't been done well enough so far, that we've made the first big leap forward and we are not done yet.

I had a chance in the last set of questions with Mr. Jackson to talk about evidence-based and, accordingly, on a variety of things we wish to do at the Ministry of Health, we require some scientific evidence and recommendation. So we had a group of people who came forward and gave us advice that allowed us to make the big leap from two to 21. We have similar groups doing work now to give us advice on what next steps are appropriate.

The bottom-line message is, and this is from a government that—I think of all the things we are really, really proud of. One of those that I know people really felt good about was our capacity as a government to dramatically expand our vaccination program. I view this newborn screening in a very, very similar way. While I think it's appropriate to acknowledge—and for anyone who doesn't wish to, the Ombudsman's interim report yesterday puts it out there plain and simple. This has been a missed opportunity for a long, long time around this place. No one's hands are clean, in a certain sense. We all enjoy some of the accountability associated with too little progress. We've made the first big leap; we have more to make, and by the time we are done, I give the honourable member and all Ontarians the assurance that it is our government's complete intention to move Ontario from worst to first. We expect that in a jurisdiction like ours, a sophisticated, progressive jurisdiction, on an issue like this, related to the most precious resource we have, these itty-bitty babies, we have an obligation to make sure that the beginning of their lives is as positive as possible.

If I could just say one word about this: There is one person in Ontario who has done more to apprise me, to cajole me, to prod me—there are probably three or four more words, and if I follow the hierarchical trend there, we'll get toward unparliamentary—and that's John Adams. John Adams was my opponent in the last election. He brings a great deal of personal passion and knowledge to this issue. I expect that before very long, I'm going to be able to look him the eye and say, "We got this done," recognizing that the opportunities to have gotten it done faster were there for all of us, but we're going to make up lost ground on behalf of newborns in Ontario.

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Ms. Di Cocco: There's a saying that I learned a long time ago, "The best time to plant a tree was 50 years ago. The next-best time is now." So I'm glad to note that we're moving forward on this.

I have to tell you that there's nothing better than holding a newborn, especially as a grandparent. It truly is an amazing experience.

I want to shift to another topic. When I was elected in 1999, probably the most urgent issue that came up had to deal with the supports in mental health. I would say that during that mandate in opposition, it was a constant issue with mental health support systems and mental health services. I met with our local mental health agency, and it was just a constant cry for this invisible, if you want, illness. It truly wrenched my heart greatly when I saw that the assistance we should have been providing in the community didn't seem to be available.

The question I have is with respect to mental health. I'd like to know what progress we're making in that capacity, because for a very long time I certainly felt the outcry from the patients, but their families as well, when it seemed that their services were just not there when they needed them.

Hon. Mr. Smitherman: I think it's fair to say that mental health hasn't over the last 10 or 15 years in Ontario been a shining example of consistent commitment. Everybody recognizes that there are always lots of pressures, but the thing that I was taken by was the tremendous consensus that existed between doctors and acute care hospitals about the extraordinary challenges they faced in their practice and in their hospital environments in meeting the mental health needs of people because of the sheer inadequacies of capacity at the community level.

I used the expression yesterday that I'm so keen on using that says that we inherited a circumstance where community-based mental organizations hadn't seen a penny of new money since before Bob Rae's hair turned grey. I told Bob Rae recently that I said that; he didn't seem too pleased about it. But it really, I think, helps to make the point that for a long time, when all of us know people in our communities, in our families, who need some help, who need someone to talk to, we let a lot of folks down. Our investments didn't keep pace with obvious needs. We made up a fair bit of ground in a couple of years. I think there are lots of areas where we have tons more to do, and this is one of them. We haven't satiated all the needs; that's for darned sure.

But in 2004-05, we invested $65 million in community mental health services. Examples of the services that we were able to enhance related to that included the development of 11 new ACT teams. I know we have one of those functioning in Sarnia, as an example, where we recently provided about $200,000 in additional funding. We really sought to try and create more of a mental health system where people with mental health challenges had some sense of connection to an agency with things like case managers or crisis response.

We're trying to also develop on the idea of accountability, that organizations that are providing these services should be connecting quite closely to individual clients, getting to know them on a name basis and taking some of the responsibility, along with those clients, of trying to enhance their quality of life. So we've brought other resources to the fore to try and package these up. That included 500 units of supportive housing targeted specifically at people with mental illness. It's not the housing but the word "supportive" that is essential there, not thinking that people are going to be in a position

necessarily to be able to sustain housing independently in the absence of support. So we tied these things well together.

We put more than 61 mental health workers in the courts. One of the things that astonishes me is the rate of incarceration. In health care, we talk about trying to limit institutionalization, i.e. limit the number of days in a hospital, because this is the most expensive place to care for people. And then there are jails. The reality is that a lot of people who go before a judge and have a mental health challenge are being remanded into places like the Don Jail, which is not going to be so good if you already have a frail state of mental health, even if the nature of their involvement with the criminal justice system was very minor. A lot of times, they're homeless or they have no place, so the criminal justice system has been putting them in jail. We've seen something like a 37% increase in terms of those people institutionalized in the criminal justice system who have underlying mental health challenges. So we sought to bring resources there.

In 2005-06, we committed another $58 million to continue with the expansion of those services and to continue to support at the community level those mental health organizations. I think we have about 353, going by memory. That gives you a sense that there's a lot of them, and we've given annualized base-funding increases to those organizations in addition to those other investments in each of the last two years.

Overall, what we're on target to do is, in a period of four years, offer expanded mental health services to almost 80,000 Ontarians. Is that going to be all? No. I think that there's more that needs to be done. We've been working aggressively on the divestment of some of our psychiatric hospitals and a variety of other initiatives, but I think that this stands as pretty good evidence of our commitment to try and improve the quality of life for those with mental health challenges and, at the same time, offer resources in a health care system that are upstream and preventive, rather than waiting for an acute incident to occur that might see a person hospitalized or otherwise institutionalized. So it's really very consistent with our whole agenda to drive resources to the community level.

The Vice-Chair: The Chair recognizes Mr. Wilkinson.

Mr. John Wilkinson (Perth–Middlesex): Good morning, Minister. There are two questions that I have, and I wonder if you could share this with me. I've always told people back in my riding, which is a very rural riding, that we have a Minister of Health who is actually the MPP for Queen's Park. So you don't get any more Toronto than that.

Hon. Mr. Smitherman: I'm from Etobicoke.

Mr. Wilkinson: But your mom's from Ravenna, so that's good.

One of the things that we've talked about—you know, as a government, you've been struggling with this and showing leadership in the need to have community-based care, to get people closer to home, and also to drive through a change in regard to integration. One of the things that I've noticed personally and something I've shared with you is the fact that in rural Ontario, where communities by nature have had to struggle together, they have developed innovative programs which we think are quite forward-thinking, models that can be used right across Ontario.

There are unique challenges in rural Ontario, and problems, but I think there are also some solutions there that have been developed at the local level about integrating care. I was just wondering if you might be able to comment about that, then. We spent a lot of time talking about the challenges, but I think there are some great examples of solutions in rural Ontario that you've been able to see. How do we export that ability throughout the whole province?

Hon. Mr. Smitherman: There are two or three ways that I can answer that question, and some of it might be a little repetitive from some of what I spoke about here yesterday.

Firstly, I know that Dr. Basrur is here. If we look, as an example, to the public health unit in your area, I think it has a long-standing reputation as a public health unit that has been progressive, on the forefront of initiatives to try and improve underlying health.

But I think, in a certain sense, I'm going to approach it more as a philosophical question, and there are two things that I'll point to that reflect our government's philosophy. Yes, I represent downtown Toronto. I'm proud of it. I like to come out to the farm country too, and I enjoy the vastness of Ontario and all of its experiences. But what I have come to learn about community is that there is no one right answer, and sometimes government is well-intended but still ends up being a bit ill-conceived in the development of policy that is one-size-fits-all, that says, "This is the hoop. Jump through it, or no dough."

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If you look at two things that we're doing, I think it reflects our philosophy well. Firstly, the family health team proposals: We've had at least one already successful in your community. What we said is that we're not going to be prescriptive about the model around family health teams. Accordingly, 213 applications came forward that reflected a lot of different approaches, in terms of the mix of health professionals within them, in terms of the governance model they use. Some of them are pure community-based models, looking quite a lot more like a community health centre, some of them are more provider-based models, and many of them are blended.

I think what I'm proud of is that from the very earliest days, we said we would not be prescriptive, because we have an understanding that in Ontario, the word "community" matters a great deal to us. Not all of Ontario has evolved in the same way, not all local needs are the same, and family health teams are one of those places where we sought to reflect this idea that we need to not be prescriptive and allow community to help define what it needs for itself.

Then there are local health integration networks. There are a lot of people who try to see these things as so high-minded that they can't get their heads wrapped around it very well. But in a simple sense—am I out of time?

The Vice-Chair: Yes.

Hon. Mr. Smitherman: OK. I'll just finish on this point, then. Sorry, Chair.

Local health integration networks are going to be a platform that allows a good idea that emerges in one place—a best practice, as people like to refer to it—to be disseminated more quickly across the breadth of the health care system. If something good is happening in Champlain district—a discharge; a new policy like we talked about yesterday for hips and knees, where you can get people back home and into physiotherapy faster—and one hospital is championing that model, I'm not interested in the idea that other Ontarians on the other side of the province are not getting access to that kind of model. Local health integration networks are going to be more about innovations that occur in local communities being disseminated across the province, not with a view toward thinking that Queen's Park is the appropriate place to lead on all those things.

The Vice-Chair: Thank you very much, Minister. It now moves to the official opposition.

Mr. Jim Wilson (Simcoe–Grey): Thank you, Minister, for agreeing yesterday to meet with Markdale Hospital folks and the Grey Bruce Health Services people. Today, I have a similar request around the cancer centres that are proposed for Barrie and Newmarket, or York region. As you know, the original proposal was to put three to four bunkers at each site and try and get services out to people in my riding, in the Barrie area in particular, who today have no choice but to go to Sudbury or London, and some to Toronto. What's the status of those proposals, and are you going to make any decisions on them any time soon?

Hon. Mr. Smitherman: I thought you were going to ask me to take meetings with those folks. I was going to say, "Gosh almighty, I've been in both of those hospitals—

Mr. Wilson: I'm not going to ask you to take a meeting.

Hon. Mr. Smitherman: I've been in those hospitals so many times I'm pretty sure they don't want to see me again. I can't say too much because we're obviously rolling out our capital plan, but I would want to give the honourable member this level of confidence: Firstly, I'm very excited, in the evolution of local health integration networks, at the role Barrie is going to play in Simcoe and Muskoka. It's obviously an emerging powerhouse community in our province. Its growth has been very impressive. As a kid, I had lots of chances to be around there, and to see it emerge as such a progressive and powerful community means that we need to make sure that the health care resources are reflected in that environment. Similarly Southlake, if we look at the investments that have been undertaken by successive governments there, is emerging as a very significant service centre for our central local health integration network.

I would just tell the honourable member that we take very seriously the advice that Cancer Care Ontario provides to us around the necessity of continuing expansion of our regional cancer centre capacities. I think over a period of time the honourable member will acknowledge that appropriate progress is being made in those areas.

Mr. Wilson: I'm glad you mentioned Cancer Care Ontario, because their report is simply wrong. They didn't put enough emphasis, I don't think, on recommending Barrie. I don't think they have the right growth figures. Even Barrie doesn't know how many cancer patients are in the area, because they go everywhere, as you know. No slight against Cancer Care Ontario, but I'm glad to hear you've got a more open mind than just their report, because I think they missed the boat, frankly. I told Alan Hudson that at the time, and now at least I think he's going to try and catch up with his waiting list strategy. There's a bunch of patients there who are just unaccounted for. You'd have to look at every home address in London.

Heck, my own brother had to die in Grand River, way over in Kitchener-Waterloo, because there's just nothing in our area. That's crazy. So I thank you for keeping an open mind on that.

Hon. Mr. Smitherman: Can I just have 10 seconds on that? It's only to say that the rates of cancer growth obviously pose an extraordinary hardship for families and communities, and no one is untouched. All through the summer I'm sure that all of you, like me, have had so many really challenging circumstances. We're under a lot of pressure to continue to grow that.

Credit Valley just opened, and Oshawa is making progress toward it. We have additional pressure in a variety of other places. There is progress in Niagara. We need to make progress in Kingston and more progress in Ottawa.

The demands around cancer are really quite extraordinary, but I just want to give all honourable members the assurance that we really are working very hard to make sure—we've built a good system here in Ontario. It's got challenges, for sure, and keeping pace with the growth is tough, but we're making a real commitment toward it.

Mr. Jackson: I want to follow up further on the issue of Cancer Care Ontario's new-drugs fund and the drug Velcade. Minister, earlier in the discussion you indicated that, over a period of a year or so, the new-drugs fund for cancer was going to double. Did I hear you correctly? Because my understanding, since you and I got into this issue in substantive detail on the floor of the Legislature a year ago June, is that the 2004-05 budget, as I recall, was $60 million and the projected costs were $64 million. I produced a directive that indicated that there was to be pushback from the administration on drugs that come from this fund. In fact, several cancer drugs were actually delisted. Subsequent to a series of questions we

raised about Rituxan, which was the drug I referenced earlier, you did approve, in front of the media, that that budget would then go to $75 million, which I publicly thanked you for.

My understanding—and you can perhaps direct me to the section in the estimates book—is that, this year, Cancer Care Ontario's new-drugs fund is going from $75 million to $85 million. I'm at a loss to understand why you indicated that somehow this budget had doubled. Those are the figures I have, and if you could help clarify that for me, I'd appreciate it.

Hon. Mr. Smitherman: If I make a misstep here, people will bail me out, but I think that the explanation is that the decision point with respect to Herceptin and two other drugs and the costs associated with that might not be reflected in estimates, but those are decisions that we've taken as a government which will have the effect of making quite extraordinary growth in that program.

On the Provis question that you asked before that I didn't respond to, do you want to hear from me on that, or would you prefer to stick with this line of questioning? If you want to come back to it—

Mr. Jackson: Yes, if we could come back to that. Can you direct me to the estimates book where the new-drugs fund for cancer patients is?

Hon. Mr. Smitherman: On page 106. Here are the numbers that I have: In 2003-04, the program was $62.4 million, and in 2005-06, the program is forecast to be $121.6 million. So that's nearly doubling over a period of a couple of years, which is basically what I said.

Mr. Jackson: That's projected for 2005-06? I'm just trying to look on page 106 to find out where that number surfaces.

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Hon. Mr. Smitherman: Under Cancer Care Ontario. I don't have it in front of me; I'm sorry.

Mr. Jackson: OK, I've got the page. I've got Cancer Care Ontario. Can I request a detailed breakout of this? These are your global numbers.

Hon. Mr. Smitherman: Sure.

Mr. Jackson: If I am to believe that 2005-06 is $428 million and change, we're looking at a $60-million change here. I want to make sure that the entire increase to Cancer Care Ontario's budget isn't just on drugs, or that—

Mr. Sapsford: We'll provide the breakdown.

Mr. Jackson: —the drug program projection actually causes some cutbacks in other areas of Cancer Care Ontario.

Hon. Mr. Smitherman: We will get you more information on that. But let me make this point clearly: While we did send a message very strongly at the point that I announced the funding related to Herceptin, Navelbine and Taxotere—I hope I've pronounced those properly—we expect that that's an investment of about $148 million over three years. While we were proud to support that investment, I was clear in saying that these are dollars that I will be obligated to find from within my ministry's budget. I don't want to leave the honourable member with the impression that that means Cancer Care Ontario's budget, but I do want to acknowledge very clearly that this will require some reprioritization of resource from within the ministry, because we think this is an important priority. But we would not expect Cancer Care Ontario to bear that.

Mr. Jackson: I just want to say that I believe two out of those three drugs are colorectal cancer drugs. Are they the new ones?

Hon. Mr. Smitherman: Herceptin, of course, is for breast cancer, Navelbine is for lung cancer and Taxotere for prostate cancer.

Mr. Jackson: My understanding is that you've already approved two additional drugs within that that may not—that's the information I'm getting from the oncologists.

Hon. Mr. Smitherman: Oh, quite possibly, yes. I was just relating to this one announcement.

Mr. Jackson: All right. If I can request formally through the Chair the detailed breakout of page 106, so that we can isolate new drugs, and the budgeted and actuals would be appreciated in those categories.

Minister, I wanted to clarify for the record: When I raised the question about those patients in Ontario who are seeking financial coverage from the government for Velcade, you may have left the impression, and I would like you to clarify for the record, that these patients—I think when we check Hansard, you stylized them as out there shopping for some of these miracle cures that have not been fully tested.

I want to make it abundantly clear that these are patients in Ontario who aren't shopping on the Internet, who aren't looking at ads in magazines or reading the New England Journal of Medicine. These are patients in Ontario who are actively taking treatment in this province under certain circumstances where the drug is covered, and then they're deemed to no longer be covered, and it's their oncologists who are recommending that they take the treatment.

George Petrunas: In his case, his oncologist, Dr. Reece, at the Princess Margaret Hospital, has suggested that he take additional treatments using Dexamethasone and Velcade. This is not someone who's shopping on the Internet. Angelo Banducci's oncologist has told him, "You should be on this drug." They have a moral and ethical obligation to advise a patient that their life can be sustained or that there is an outside chance of remission with this drug.

John Emerson is the same issue. I've left John Emerson to the last because he is one of two very unique individuals in our province. He actually feels a bit guilty that at age 74 he has the province of Ontario paying for his Velcade, but others aren't. The other individual we've contacted is someone who approached the oncology department after they indicated they should go on it, and the oncology department found some surplus serum in their inventory, for which they said they wouldn't charge, so they've administered. That's the information we've received. So we have two people in Ontario, to our knowledge, who have received it without payment.

I want to revisit this, Minister. The clinical evidence is very clear across Canada. What are you doing about this gap with the hospitals, which are under your administration? We cannot wait for Helen Stevenson to finish her work. She may not report until next year some time, since her consultation document isn't even coming out until this fall.

Hon. Mr. Smitherman: With all due respect, I think it would be far more appropriate for you to read back transcripts rather than continue to operate on characterization after characterization after characterization, including characterizations of science, which is something I'm not going to be involved in. I think this is a very dangerous area to proceed in the way that you're choosing to today.

I very clearly said, and the transcript will demonstrate this—you have decided to take some comments that I made and apply those to Velcade, when I was applying them more broadly to the issue of new cancer drugs. I'm trying to approach the issue in its entirety because I've been very clear in saying that as a politician, as the Minister of Health, I depend upon evidence-based processes and I do not get myself in a position—at least I work very hard not to—of making clinical analyses. I depend upon people who are at the DQTC to do that.

When the member refers to discussions on the Internet and the like, I was merely making the point that is well known. André Picard, as an example, from the Globe and Mail has been doing a very effective job of trying to help Ontarians and Canadians sort their way through this very difficult situation as it relates to new product that is available very regularly. That's why I'm very careful not to be involved in characterizations—

Mr. Jackson: Thank you, Minister. I appreciate the comment.

Hon. Mr. Smitherman: —along that line.

One other point where you were wrong that I think it's appropriate for me to be given an opportunity to comment on is that Helen Stevenson is doing work, and you have decided to create timelines related to that work. I can assure you that the timelines we're working on are far more ambitious, and I expect that we'll be in a very, very strong position to move forward within a range of three to six months.

The Acting Chair (Mr. Jim Wilson): You have about three minutes left, and Mr. O'Toole wants to ask questions.

Mr. Jackson: All right. I'll just be very brief on this point. Minister, the comments you've made today are similar to ones you made about Rituxan, and you even went so far as to say I was misleading the House with the information. I had done my homework. The science was clear. You were forced to provide additional funding to cover this drug. I submit to you that you are in a similar position with respect to this drug, or close to it. I'm merely asking you if it is not a priority for you to straighten out this gap. Your own ministry officials, Peter Finkle in particular, approved this drug for John Emerson. I'm asking you, how can you reconcile a bureaucrat saying, "Yes, there's a gap; we will fund it for one individual in this province," and yet you remain silent in terms of how you're going to deal with it? Was it that big a mistake for Mr. Finkle to provide this life-saving intervention for Mr. Emerson, and are you prepared to revisit this issue since the oncologist says it will work, and clearly your ministry has, by providing the funding for Mr. Emerson, created a precedent here?

Hon. Mr. Smitherman: Again, you're right back into the characterization of a drug that I think is bordering on irresponsible.

Mr. Jackson: So what are you doing with Mr. Finkle?

Hon. Mr. Smitherman: I would advise the honourable member that I don't think that's an appropriate way to move forward. As I said before, we're working through the DQTC with respect to Velcade and with other product that comes forward. That's the science-based, evidence-based method that we have in this province to move forward. We have sought additional information as it relates to this product and we'll be working on the basis of the advice they bring forward to us.

The Acting Chair: Mr. O'Toole.

1020

Mr. John O'Toole (Durham): Very briefly, Minister, I would like to submit, because of the time constraints, four written questions: one requesting a meeting with Lakeridge Health dealing with their 300-plus layoffs, as well as meeting with the Port Perry community on the Port Perry governance issue at that site. The second one will deal with a letter that you've had in your possession since April 29 dealing with out-of-country coverage, dealing with drug treatment at the Mayo Clinic. The third one is on the issue of a young person who has had an adverse reaction to hepatitis B. It's to the medical officer of health. That letter has also been sent. The last one is dealing with the issue of community mental health, which you briefly touched on earlier, and the courts' and the police front-line services' inability to deal with community mental health in what I'd call a more civilized fashion, at great risk to those persons suffering ill mental health. I'm just putting that on the record. I will submit those to you.

The Acting Chair: Thank you. The time has expired.

Ms. Martel: I just want to return to the line of questioning around community-based agencies. Just to be clear, in the direction that was given—if direction was indeed given—to community mental health agencies, the money that was allocated, then, was essentially for base budget; not for new programming, but to support the base budgets?

Hon. Mr. Smitherman: No. They're significant new resources for new programming. That's how we're expanding services that will result in an additional 78,000 people being treated over a period of four years. So there have been base funding increases of 2% and 1.5% in the last two years and, in addition to that, significant program expansion designed to provide additional support for over four years of 78,000 clients. So continued expansion, but over four years we expect 78,000 additional clients to receive service. I did outline in an earlier answer some of

those expansions, like 11 new ACT teams—just as one example of the kind of program expansion that's ongoing—and some 61 additional workers in courts, designed to assist people with mental health, as an example. These are all new services.

Ms. Martel: Can I assume that those services will be funded on an annual basis? It's not new one-time funding for a particular project; this is going to be annualized into base—

Hon. Mr. Smitherman: Oh, I'm sorry. It's new funding to base for additional services, and escalating growth over four years.

Ms. Martel: That's factored in over the four years.

Hon. Mr. Smitherman: Yes, those programs will continue to grow.

Ms. Martel: I looked at the allocation for addiction, and it's about $2 million for about 150 agencies, so I have to assume—sorry, this is on page 132 of the estimates. I'm assuming that's not in addition to base and it might be a couple of particular projects, because with 150 agencies it would be hard to see that as an increase.

Hon. Mr. Smitherman: No, it's a 1.5% increase—I think that's right—on base. I think the base on addictions is $114 million or something like that, so those numbers would seem pretty accurate.

Ms. Martel: You said about 150 agencies, so is every agency getting a 1.5% addition to base? Yes, I'm seeing some nodding at the back. OK.

The addictions—that would still be keeping them behind in terms of where they have been for the last number of years. I don't know what commitment they have been given in terms of trying to do a bit of catch-up. There's been catch-up that's going on on the community mental health side, not essentially on the addictions side. I wonder, Minister, if you can just outline either what direction they've been given or what your plans are to try and move some of those addiction programs out of a situation where they were essentially laying off staff to a position where they'll be able to be providing new programs as well.

Hon. Mr. Smitherman: I think the honourable member is right to touch on this as one of those areas where more resource is required. Although we separate them out for the purposes of these discussions, we do have an expectation that additional resources for mental health are capturing some of the same clients who might have addiction challenges, the recognition being quite strong that these things are often co-identified. So I think that, broadly speaking, additional resources dedicated to the expansion of mental health are going to lend some additional assistance to people with addictions, but it doesn't separate the fact that this is an area where there are obvious ongoing opportunities to enhance the amount of resource that's available. We're constantly looking for opportunities to be able to do so.

Ms. Martel: Can the ministry provide any indication as to wait lists that might be in place on the addiction side? Is that tracked on a consistent basis through the ministry, and can you advise if the funding that will be allocated this year would essentially clear waiting lists, if those exist, on the addiction side?

Hon. Mr. Smitherman: If the deputy has anything—I don't know. I don't know what we have at hand, but that's something we could take a look into and get back to you.

Mr. Sapsford: There would be nothing immediately available specifically on waits that we would have from a provincial basis.

Ms. Martel: Are they tracked at all through the provider agencies to regional health offices of the ministry?

Mr. Sapsford: No. They would keep track of their own caseload and their own waits but I'm not aware that that's brought forward to the ministry.

Ms. Martel: For what it's worth, in public accounts a couple of years ago we looked at the issue of waiting lists and were they tracked and were they standardized. The committee at that time made a recommendation—it was both Comsoc and Health at the time—that it would be appropriate to take a look at that, partly because you could then make some more astute decisions about targeting resources in either geographic areas or underserviced communities that had long waiting lists. It would be appropriate for the ministries to be in a position to do that to make some really good funding decisions, particularly in areas where there were big backlogs or long waiting lists. I just mention that again.

There was one other question that I had with respect to mental health but it has more to do with peer support, both programs and initiatives. Minister, you may have received this and you may not have had a chance to look at it, but I think all MPPs did. It was a document that was put out in conjunction between the Canadian Mental Health Association, CAMH, the Ontario Peer Development Initiative and the Ontario Federation of Community Mental Health and Addictions Programs. It came out in July and I think all members were actually given a copy. It was a very good document which essentially looked at how important consumer survivor initiatives are in communities, the research that actually is in place to show their value and their effectiveness, the very significant financial hardships that they are facing, and also made a number of recommendations about how consumer survivor initiatives could be improved.

I raise it here because I thought the document was extremely well done. There were some very important recommendations, many of which, to be frank, focus on a need for increased funding, but many of which focus on a need to really have ongoing and increased government support for consumer survivor initiatives. They were first funded under our government through Jobs Ontario. There really hasn't been an increase. Many are facing significant financial dilemmas; many have gone under. I think it would be very important for the ministry to take a good look at this important work, because the recommendations are quite outstanding and, in the long run, would benefit many of the consumer survivors who are actually requiring that support, who are able to be supported outside of institutions—I don't like to use that

word—many of whom can have gainful employment as well, with some of that additional support.

Hon. Mr. Smitherman: Let me tell you this. I'm going to garble the name a bit, but I know you'll get what I'm talking about—peer support consumer/survivor network. Am I pretty close to ringing a bell there? There's a very passionate woman who is involved in that program. I can't remember her name, but she sent me an e-mail the other day that said, "True to your word," more or less. The consumer survivor initiatives are ones that I have long-standing attachment to and support for. I've got some really great models in my own riding.

Just a couple of weeks ago I had Senators Keon and Kirby, who are working on a mental health report for the Senate, come and visit my riding. We went to three places, all of which are models. One of them is a peer consumer survivor initiative that is on Parliament Street. The other two places—Progress Place and St. Jude's—are places where the peer support model really has been at the heart of those folks thriving.

I'm working on raw numbers here, but I think that we're funding consumer survivor initiatives in Ontario consistent with what was around in the days of your government, at around $4 million. I don't think that they've really moved, but they have moved now. We've increased that funding by at least $1 million. We're going to distribute some of it to help to build the networks of consumers to give some annualized support so that networks can emerge, which is one of the things that they've been looking at.

Among the expansion of mental health dollars that I spoke about earlier, some consumer survivor initiatives—like the one called Sound Times on Parliament Street, which I know best. That's run by Lana Frado, a name that might be familiar to you. We've actually deployed them as a new service provider using mental health dollars.

1030

We can get you better numbers on this, but overall I want to let you know that I believe the consumer survivor community in Ontario at the moment feels that the government is moving forward in a fashion consistent with the advice they gave. So basically we had some additional amount of resources available. We met with a group of them and I got some advice about the best way to spend those dollars, and we're in the midst of making new investments in an area that I think hadn't received any new money in quite a long time. We can give you a bit more specific information.

Ms. Martel: OK. You mentioned a $1-million allocation. Can I get a sense of what that breakdown is? The request in the document is for about nine, so I think $1 million is better than not moving forward at all.

Hon. Mr. Smitherman: We also brought some mental health dollars into those environments, so overall, the number will be more than $1 million. We'll get you all those numbers.

Ms. Martel: I would appreciate some information about the Sudbury situation particularly, because I have been dealing with the regional office. I've met with peer support. I was on site and met with a number of consumer survivors. We've been going back and forth since an application went in for funding probably in May, and there's still not an indication yet if there's going to be some financial assistance. It would be—I don't want to use the word "amalgamation"—a joining of NISA and also peer support in Sudbury. They were working on a new governance model etc., but the application for funding, as I understand it, is still outstanding.

Hon. Mr. Smitherman: OK. We're happy to take that up.

Ms. Martel: That would be great.

I want to ask some questions now about hospital development and redevelopment. Many of these questions were raised in estimates earlier this week with Minister Caplan, but because so much of this is occurring in the hospital sector, I wanted to raise them here in estimates today.

I remain very concerned about the government's decision to focus on private financing of hospital development and redevelopment. I think it's worthwhile to go back, on the record, and take a look at what the Liberals said before the last election, because Mr. McGuinty was very clear about private financing. He said in the Ottawa Citizen, May 28, 2003, "What I take issue with is the mechanism. We believe in public ownership and financing (of health care)." Further in that same interview, "Mr. McGuinty believes that public/private sector partnerships in health would ultimately cost the province more money than traditional arrangements." Also, a little bit later in 2003, again to the Ottawa Citizen, September 24, "Ontario Liberal leader Dalton McGuinty has said the ROH expansion will go ahead because Ottawa needs a new psychiatric hospital, but a Liberal government would cancel the deal with the private sector consortium because public/private partnerships are a waste of money."

It's very clear in the hospital redevelopments that have been announced that the government is moving wholesale into private financing of these hospital projects, which clearly is a breaking of a very specific election promise and of much concern to me because the Premier has already admitted that it costs more. Minister, why is the government moving to private financing of hospitals when the government was opposed to that before the election and when these very important hospital projects should continue to be funded in the traditional way with public financing to get the best bang for the public dollar?

Hon. Mr. Smitherman: I say three things. First, there was a lot of time spent on this the other day with the minister who is responsible in our government for helping ministries like mine satiate as much of the extraordinary demand that's there for new capital projects, and we've heard quite a lot about other projects. I think that ground got most of what it needed the other day.

I would say two things, maybe. First, you said "wholesale," and I would just caution the honourable member to acknowledge that a wide variety of health care projects

are moving forward in the traditional funding manner that she advocated in her question. I would just say this: In an environment, in northern Ontario, just as an example, where we can point to cost overruns at the Sudbury hospital or the Thunder Bay hospital, I don't think it's quite so easy to say that those are the most cost-effective models for the taxpayer. If you look at the tradition that has emerged in our province, if you look at the challenges that we had a chance to speak about yesterday with the Health Services Restructuring Commission, where projects have come in at costs two or three times greater than what was predicted, you see very great hardship in the traditional model as well. People like to focus—and I know that there was some discussion between the leader of the NDP and Minister Caplan the other day about costs, but I think it's appropriate in the context. I think a lot of residents in northern Ontario would be familiar with the idea that there have been tremendous costs built into our record of construction in the traditional model. The risk take-back associated with private sector involvement is a conditioning, a discipline, that I think over time is going to reap important rewards for Ontario.

The bottom line for me as the Minister of Health is that according to the OHA, in their most recent stuff, we have something like $8 billion of insatiated hospital construction in Ontario. It's obvious that to get as much done as possible, we need to be flexible in the variety of ways that we can move forward. The government is taking the view that being able to advance our $30-billion infrastructure plan over five years is important for the future of Ontario. Accordingly, as not all of those resources are present at the time, it's appropriate to act as most people do when they buy a house, which is to make that purchase over time.

I think there are compensatory issues associated with some of the models that are now available to us that have tremendous advantages to taxpayers. As I mentioned, the discipline around project cost and timing stands as one of those that make it easy for me to say that I'm proud of the flexibility of models that our government has developed around these things.

Ms. Martel: If I might, in response, Minister, the cost overruns in the Thunder Bay Regional Hospital and the Sudbury Regional Hospital—those problems were well-known before the last election. They were well-known in a very public way. Your colleague Mr. Bartolucci and some of your colleagues from northwestern Ontario made that case. That didn't stop the Premier from making the commitment he did before the last election to not use private financing. Those details were well-known before the Premier said what he did. Secondly, the fact that there were a great number of hospital projects in the queue, primarily as a result of what went on during the Health Services Restructuring Commission, was also very well known to all of us in a very public way. That didn't stop the Premier of the day from making the promise he did, that hospitals should be publicly financed. Mr. McGuinty was very clear, and I agree with Mr. McGuinty that it is going to cost more to privately finance hospital re-development than it would if we would fund these through traditional arrangements. We are very supportive of the projects that are going forward, but we believe very strongly that they should be funded publicly in the very way that Mr. McGuinty promised before the last election.

Your colleague Mr. Caplan admitted on the record in the estimates process that the AFP process is going to be more expensive, because the borrowing costs are going to be higher, because there's a risk premium built in and because there are inflation escalators built in as well. I don't understand why we are going to use money that could be much better spent, for example, on patient services, to finance instead the profits of the private sector consortiums that are going to be involved. We should be using the traditional arrangements, just like Mr. McGuinty promised.

Hon. Mr. Smitherman: As I said at the outset, you want to have the same debate two days later in the same committee. I think there was a good hearing on it. I had a chance to catch a second or two of it. I'd like to make a couple of points. Firstly, you want to talk about a queue and blame the HSRC. As a member of a government that for five years, frankly, didn't do very much building of hospitals, I think you really should fess up to some of the obligation and responsibility around the extraordinary list that emerged. Not making investments during that period of time did have the effect of creating some of the challenge that we have in an aging stock of hospitals. You had fiscal—

Ms. Martel: You'd want to check that through Jobs Ontario to see the level of our investment. Sorry. Wow, my goodness.

Hon. Mr. Smitherman: I've travelled around to a bunch of hospitals. I haven't been—

Ms. Martel: There were cutbacks on the operating side, not on the capital.

The Acting Chair: Excuse me, Ms. Martel, you have about one minute left, if you want to wrap up your remarks.

1040

Ms. Martel: Sorry, Mr. Chair.

Hon. Mr. Smitherman: Is it all right that I finish my answer, Mr. Chair?

The Acting Chair: It's up to Ms. Martel.

Hon. Mr. Smitherman: She asks a question, and I don't get to answer it?

Just on one of the other pieces, on Thunder Bay, you say that everything was known? This is not accurate. The Thunder Bay project was not even complete at the time of the 2003 election.

Ms. Martel: Hmm.

Hon. Mr. Smitherman: It wasn't known. We had Tom Closson do a report, and it's at that time that we came to understand that using the traditional model had resulted in more than a doubling of the costs associated with the construction of that project. Inherent in that $120-million cost overrun is a lot of opportunity for Ontarians to benefit with risk take-back and transfer to

the private sector. So I think that these models will hold us in good stead as we seek to upgrade as much as possible of our hospital infrastructure in the province.

The Acting Chair: Time has expired. Thank you, Minister, and thank you, Ms. Martel.

Mr. Lorenzo Berardinetti (Scarborough Southwest): Good morning, Minister. I just wanted to ask you a question about the state of our public health system. As everyone knows, the SARS crisis was a wake-up call in Ontario in terms of the province's ability to deal with infectious disease outbreaks. Could you tell me and the committee what our government is doing and has done to ensure that we're better able to prevent infectious disease outbreaks, and also how to deal with them when they inevitably occur?

Hon. Mr. Smitherman: Well, I think the first thing that's important to express is that Ontario is a jurisdiction that faced down SARS, where 44 of our fellow Ontarians lost their lives. We have an obligation to operate every day on the idea that we must learn and apply these lessons. That is the fundamental obligation. That is our starting point on this initiative.

Then, what flows from that is what I can most easily or appropriately describe as a comprehensive response. First and foremost, we think that leadership is a very important contribution to good-quality public health, and accordingly, our government continues to be—this'll be good—applauded from many quarters for the decision that we made to ask Dr. Basrur to come and serve as our chief medical officer of health.

I think, in addition though, I'd like to go through a list of some of the things that we've done. Firstly, governments initiated a variety of inquiries—I'm just going to use the word "inquiries" in the broadest sense—to gain some insight into what an appropriate response should be. The federal government brought in Dr. David Naylor, who's well-known, of course. Dr. David Walker, the dean of health sciences at Queen's University, was brought forward to help create an expert panel to give advice around how to deal with infectious disease control. Of course, Justice Campbell as been doing some exemplary work in investigating what went wrong, and more appropriately, what could be done.

What we have sought to do as a government is to address the recommendations that they bring forward to the T. The best thing that I can offer you as signs of progress is that, to the best of my knowledge, all of those gentlemen, when asked to comment about initiatives of the government, have expressed a high degree of satisfaction. We're not resting on our laurels, not at all. We've been working very, very hard, and now I'll go through a variety of things that we've been doing. You may want to ask me for some feedback.

Firstly, the government of Ontario is in the midst of taking back more responsibility for public health: We're footing more of the bill. Simply, in a province where resources are not always equalized, we want to make sure that every Ontarian has access, that there is good public health capacity in their local community. We've created a provincial advisory committee around infectious disease, and it's operating very well. Again, we build on this theme of the system helping the system, and we engage experts from the system to help to inform others about how to go forward.

We've been working hard on the development of a Web-based integrated database for all health units to deal with when there is a disease or an outbreak. This isn't sexy stuff, but it's expensive, and it's essential to build a good data management capacity. We really didn't have that. People will remember those stories about SARS where they were using Post-it notes on boards and all of that. We've worked hard to enhance our capacity.

We will next year be establishing a new health protection and promotion agency. This was recommended by the Walker panel, and at current there's a very big group being chaired by Dr. Terry Sullivan, the president of Cancer Care Ontario, that's giving us more advice around that through what's called the agency implementation task force. That's co-chaired with Dr. Sullivan by Dr. Dunkley, a former associate MOH in Ottawa.

We've got a capacity review committee working to advise the ministry, through the chief medical officer of health, on the core capacity required at local levels. I know a lot of people have been working very hard on that.

We have a public health e-council which is working to create more information technology capacity as it relates to public health, and we're working on the implementation of four initial regional infection control networks.

It's a bit of a shopping list, but it falls under that umbrella, which is that as a government, our starting point is that we owe it to our citizens and especially to those who lost their lives to make sure that we appropriately apply all lessons learned. We employ experts in giving us advice and we have inspired leadership in the form of Dr. Basrur, who works with a very, very broad sector of people out there, at what I might call the front line or the community level, who are so essential, obviously, in helping to disarm these kinds of situations if and when they emerge.

The Acting Chair: Thank you. Mr. Milloy?

Mr. John Milloy (Kitchener Centre): Minister, I'm going to tell you and the committee that I may have a bit of conflict of interest in asking this question, because I want to talk about newborn screening, just to follow up on what Ms. Di Cocco said. As I think you know, Minister, my wife and I are expecting our first child in about two weeks, so I hope I'm allowed to ask it.

Obviously, as a prospective new parent, I'm following with interest the information in the media, some of the measures that you've brought forward and obviously the Ombudsman's report that came out today. The one thing, though—I'm looking at the Globe this morning, and I believe it's mentioned in other articles—is this whole issue of not covering sickle-cell anemia, that that has not been covered through this. My understanding is that there are a lot of very solid medical arguments for covering

this, and at the same time it's being done in other jurisdictions. So I'm just wondering what your response is to these press stories and if you're looking at it.

Hon. Mr. Smitherman: I'll try not to go over all the ground that I spoke about in my earlier response. But the one thing that I think is really important to repeat is that even at the time that we were able to make that big leap forward—I won't go over it in painstaking detail, but we've added a considerable array already—at that time I said, "This is the first step." What we were doing was operating on the interim analysis that came forward from the experts that we had assembled, but we did not have all of the advice or all of the experts assembled at that point to give us advice on the broadest array of opportunity that we had to address.

I'll use sickle-cell, because I think it is one of those that is receiving significant attention. The message that I have sought to send, but I feel like I've not done it well—so perhaps today we'll be more helpful on that—is that we have not bypassed sickle-cell; we have not said no to it. I simply await the advice of experts that are going to give us advice on sickle-cell and a variety of other things that we can screen for as we seek to move Ontario from worst to first. I think that some of the frustration emanates from the fact that since 1992, the scientific community, if I could use that expression, has been advancing to the government of Ontario the need to get there. Maybe I could say that there's enough blame to go around, if you will, for not moving forward, but I'm not so interested in distributing that; I'm interested in action. Accordingly, I would just want to give some assurance to those who feel like their issue has not received attention yet that we're working very aggressively. We know that Ontario has started from behind, but we will bring considerable energy to bear with a view toward enhancing our capacities, and sickle-cell is amongst those that I am awaiting advice around.

One more small point on this: One of those who has been engaged at a community level around the issue of sickle-cell is former Lieutenant Governor Lincoln Alexander. I had an opportunity to speak with His Honour last week, and I gave him a similar commitment in person, that I expected to be in a position to stand alongside him and others at an appropriate time and say, "We've made up for progress that has been too long in coming in the province of Ontario." That's a commitment that I make again before the committee and that I'm prepared to be held accountable to.

1050

Mr. Milloy: As we're sort of getting toward the end, I'm going to switch gears and move to wait times. I was very interested in some of your comments yesterday. Obviously getting a handle on wait times allows us to explore where there is capacity in the system and generate or grab hold of unused capacity and, at the same time, where to put resources forward.

You've talked about the possibility of a Web site coming forward. You talked about expert panels. I just wondered if you could sort of pull it all together. What's our strategy? How are we going to be measuring reductions in wait times moving forward? And third, how is the public going to be involved; how are the actual users of the system going to have some input?

Hon. Mr. Smitherman: Mr. Chair, I'd like to introduce Hugh MacLeod. He's the associate deputy minister and the head of our health results team. Hugh, you might want to expand somewhat on the nature of the measurement and the involvement in expert panels. Those are at least two of the things that I heard the member ask about. Thank you.

Mr. Hugh MacLeod: Thank you for the opportunity to talk about this very exciting initiative.

We started with a simple premise: Let's begin to challenge the current assumptions upon which we have framed our work. In that process, we have engaged literally hundreds of thought leaders in the system.

The first question we put in front of them: Are wait times really a symptom of a bigger issue? The bigger issue is access, and part of that issue is management of the system, management of that access. Through the good work of Alan Hudson, who brings both a local flavour, as a neurosurgeon, and who as the former president of Cancer Care Ontario understands the system linkages, of Peter Glynn, who brings the Saskatchewan experience, in that he brought to Saskatchewan an overall strategy for wait time, and the real glue piece within the ministry, Rachel Solomon, who begins to take all this good work and crystallize it and put it in a frame, we began to map out a blueprint that basically has five elements. The minister has talked about the first two elements. The first one is volume, to begin to address the backlog. The second one was the introduction of new technology, like new MRI and CT capacity, to make the system more efficient.

But companion to that, we knew there were opportunities to improve the throughput of the system. So the first initiative we looked at was the critical-care capacity of the system. We have engaged 44 experts from the system, 44 physician leaders, who have developed for us a 90-page briefing document with a series of recommendations on how to improve critical-care throughput and thereby begin to take care of some of the bottlenecks between emergency and the ward, and the ward and the operating theatre, to assist us to improve access.

But we didn't stop there. We also engaged a number of other experts. We have an expert panel on MRI and CT, and they have published a report. This is the first provincial report ever published on MRI and CT; likewise, the first provincial report on cataract, the first provincial report on hip and knee, and a companion piece to that, because what these reports told us and informed us was that there was opportunity through a better analysis of the surgical process for surgical improvement. Let me highlight some of the findings on the surgical throughput.

We had an overwhelming response from the hospitals: 96% of the hospitals responded to our survey. That was encouraging, because that kind of dovetailed into our

front end in terms of challenging the assumptions, and people now are beginning to have a different conversation with us.

What did we find? Thirty per cent of the hospitals have no system for sequencing patients from their surgical day, 19% of hospitals do not track the start time of the OR, and 27% do not track cancellations. On those three quadrants alone, there's tremendous opportunity in the system.

It begins to challenge the assumption that Ontario hospitals are the most efficient hospitals in Canada. They may be, but compared to who? What the experts have told us through their work is that Ontario hospitals can become much more efficient. So we are encouraged by these expert panel reports, because the common themes that are coming out of the reports are as follows: the need to move toward greater standardization of practices; the need for a renewed focus on quality and safety; opportunities for efficiency and effectiveness; the need for better information; the need for stronger accountability and performance metrics; the need to be creative on our HR models; and more importantly, the need to transfer knowledge across the system. LHINs begin to become an important catalyst to take this foundational work forward to again engage all the parties within the geographic area in a different conversation.

We also put out a proposal for projects on two dimensions: One on education, and one on innovation. We had over 200 individual organizations respond to our proposals. We approved 18 on the education side, and 36 on the innovation side. The framework that we used to make the selection: All of these projects had to look at ways to improve access and therefore reduce wait time. The second part: All of the proposals had to have built into them an element of how the local organizations who put forward the proposals would develop a strategy to transfer the knowledge. Let me give you two examples of what we're looking at in this collection of 18 and 36 proposals. At Humber hospital, they are developing a tracking system to track the patient from primary care, through the hospital, into the community to begin to understand the flow, but more importantly, to begin to understand the break points where service is disrupted. In the Toronto area, 26 organizations have come together to develop a strategy to reduce length of stay through a rehab strategy that will assist us to free up more capacity to deal with wait time issues.

The Acting Chair: You have approximately four minutes left, Mr. Milloy.

Mr. Milloy: Just to follow up, the minister has mentioned the Web site that's coming up. The individual user of the system obviously benefits in the sense that the wait times are lower but, at the same time, an increasing knowledge of where the wait times are and the comparisons. How are we going to be dealing with the increased capacity or the availability? And then, what's the individual's role?

Mr. MacLeod: Two parts. The minister made reference yesterday to the first report, which was the ICES report using 2003-04 data. It began to foreshadow the future, because for the first time we're able to look at an aggregate number by LHIN geographic area of how long people are waiting. We're now into our next evolution, and that is now populating that map by hospital, using this year's data, to give a demonstration of how long people are waiting.

There are two values: one for the consumer that shows the consumer that in hospital A the wait time for this activity is X, and in a neighbouring hospital or a neighbouring LHIN it is different. So there is an opportunity for the consumer to make a choice with his or her family physician and surgeon. More importantly, however, what it provides is an opportunity to look at equity, to look at where we have our significant issues and challenges in the system. As we move forward with the different levels of funding volume announcement, we factor all that into our decision tree to ensure that the principal of equity is maintained.

The last piece in the sequence is that by December 2006, we will have for the first time a live registry capturing 80% of the wait time volume in the province. It's a first for this jurisdiction, and we believe it will be a leading indicator for not only this jurisdiction but for the rest of Canada.

Mr. Milloy: Can I just ask, as follow-up—perhaps this is a naïve question about doctors' referral patterns and the involvement of patients and things like that—once the Web site is up and running, once some of these fundamentals are in place, how is it going to work practically? Are you going to be promoting it amongst the medical community, amongst the public? How do we encourage people, or what are the mechanisms for someone to say, "OK. The wait at my local hospital is X, and yet there's one two or three hours down the road which is a lot faster"? How does that whole infrastructure work, in a more structured way?

Mr. Sapsford: I think the information is important at first to frame the discussion. The expectations of the ministry in the future around these issues will be to increase the requirements for productive performance. It's important that hospitals and their physicians understand their relationship to other hospitals so that we can have a broader discussion among hospitals about how best to serve the public in that part of the province. So what we're trying to encourage is cross-hospital discussion, cross-LHIN discussion, so that we can focus the hospital resources and surgical resources to get the best possible care in as timely a fashion as possible. So I think it's a very positive benefit that the information, in the hands of patients and consumers, will in effect encourage that kind of discussion and improvement in results over time.

1100

The Acting Chair: Thank you very much. Time has expired. Thank you to the government members. Mr. Arnott, this is the last 20-minute rotation.

Mr. Ted Arnott (Waterloo–Wellington): I want to thank the minister for being here today to answer some of

the questions that members of the Legislature have for him.

Minister, I want to ask you a clear and specific question about capital funding from the province for hospital redevelopment projects. According to my files, in January 2004, some 21 months ago, I first brought to your attention a number of issues facing the Groves Memorial hospital in Fergus, including the hospital's ambitious and visionary plans for redevelopment to meet the health care needs of my constituents into the 21st century. This hospital has spearheaded a very successful fundraising campaign, raising some $15 million in donations and pledges, an extraordinary sum for our small communities in the hospital's catchment areas. Minister, you've visited this hospital—you know the people and you know how great it is.

Now we're waiting for Ministry of Health approval to commence the next stage of planning for the redevelopment, and I understand in the ministry's terminology, it is approval for functional planning. That's what we're talking about. I've raised this issue in the House on October 14, 2004, on April 13, 2005, and in a letter to you dated June 22, 2005. Our community has been very patient, but as the MPP for Waterloo–Wellington, my patience is beginning to wear thin. When exactly will you, as Minister of Health, grant Groves Memorial hospital the approval it needs to move forward with the next phase of planning for its redevelopment?

Hon. Mr. Smitherman: My patience has run thin too with the circumstance that I inherited, where more hospitals were promised than could possibly be built, and Groves gets caught up in that.

A couple of things that I'd like to say: Firstly, Groves Memorial is a good hospital. I like the scale of that hospital, and the way that the primary care physicians in the community are also the hospital physicians. I was pleased that we were able to support the emergence of the family health team adjacent to the hospital. You're right to say that the next step for the ministry, in offering support or progress toward Groves, would be the extension of a planning and design grant, that is, to get to the point of having a functional plan.

I have had a chance, as you've said, to witness the extraordinary community support that exists for that hospital, but the bottom line looks an awful lot like this: You're pretty aware, in the region, that there are projects so much further down the path than Groves, in terms of having had their planning completed and the like, that as a result of our fiscal limitations and some of the expectations that have been developed—we talked about this quite a lot yesterday, and I won't belabour the point. I can't tell you exactly when we will be in a position to move to that next stage with Groves, because the sad reality is that there is already, in Ontario, such an unsatiated amount of capital that we have to be careful.

What I'm not interested in doing is this: I already have plenty of expectation that has been seeded in communities. Getting Groves to the point that they've completed their functional plan and have all of that planning work done will have the effect of enhancing their expectation about going forward. At the moment, in the circumstances that we're facing, I worry that that would be unfair to the community. What I'm just trying to say to you in a very plain-spoken way is, I know that there are health needs at Groves, I know that there is tremendous community support and they're ready to get going on this. But the sad reality that we have to face down is that even though we're advancing tons and tons of hospital projects, we do not at the moment have the capacity to move all of those forward that are ready to go. I just want to be careful in not further inflaming expectations in your community in a fashion that the government of Ontario is not in a position to meet them.

I'm not saying no to the extension of the planning and design grant, I'm merely letting you know of the caution that I'm bringing around that. I do feel that in my earliest days in the ministry, we advanced a planning and design grant in one or two places that may have created an expectation that, as it turns out, is a little more artificial than I would have preferred. I don't want to mislead the folks of Groves in your community and get them further down a path that maybe isn't going to result in exactly what they need. It's a bit of a wrenching thing, but it doesn't do anything to diminish the need or the support that exists in your community. I want to get there with you as fast as I can, but it's not easy.

Mr. Arnott: I'm somewhat disappointed by the answer because I was hoping for something more positive. But I would have to say to you, Minister, that the expectation is raised by the need that exists in terms of the improvement of health care that people in our area deserve, and certainly the expectation to some degree is fuelled by news of announcements for capital in other areas of the province.

Clearly, you have a list of capital projects that you're prepared to approve. I don't know how you prioritize them, but you're going through them, I suppose, on a weekly or monthly basis to make those announcements. The people of Centre Wellington in the catchment area of the Groves Memorial hospital have an expectation, you're right, because of the money that's been raised.

I would again say that the approval for functional planning, as I understand it, will allow the hospital to move forward to the next stage. It will take at least a year, I'm told, to do the functional planning. So the people at the hospital and the community understand very well that it's not going to happen overnight, but they're looking for support from the ministry to move to the next stage and move forward. Obviously, that proposal has my absolute support.

So I would ask you again: Would you be willing to express to this committee today, so that I can tell my constituents, that you're supportive of this hospital redevelopment plan and you're going to do what you can to move it forward?

Hon. Mr. Smitherman: No, it would be irresponsible for me to give you the undertaking today that you want, specifically as you've defined it, on the basis of next-step

progress perhaps within a year. This is not realistic in the current environment in Ontario. Although it's disappointing news to you and to your community, it is honest news that I think, frankly, you could have used a whole healthier dose around as it relates to hospital capital over the last five or eight years.

I gave the long explanations yesterday, and I can't remember if it was the part that you were here for, but if you look at the combination of things related to growth in our province, the commitments of the Health Services Restructuring Commission—you see in your own region some of the challenges that we're facing.

We have made some pretty significant investments in Waterloo–Wellington. We have significant family health team resources there. We've been expanding resources around community-based care for people with HIV/AIDS. We've been working to expand our capacities around community-based mental health, and our government will look for all the opportunities we can to make investments that are due. I recognize that this is an unmet need. I can't give you the undertaking that you wish to get today, but I give you and the people of your community my commitment that, at the time that it's appropriate to move forward with the planning and design grant, the government will be there to do that. But I don't wish to further inflame their expectations, as I think that that would be unrealistic.

Mr. Arnott: Thanks, Mr. Chairman. It looks like I'm going to continue this dialogue with the minister in the Legislature in the fall session.

The Acting Chair: Mr. Jackson.

Mr. Jackson: I just want to finish my line of questioning with respect to cancer. I'm concerned that we do not have a national cancer strategy and that the federal government hasn't been able to line up its priorities in a fashion that would please the provinces in terms of their efforts in this area. But the Canadian Strategy for Cancer Control doesn't seem to be going very far in the discussions that have been shared with me.

As you know, Minister, the primary role for the federal government is prevention and funding, but all treatment is done provincially. When I look at the amount of commitment that's being made by each of the provinces and the results on a per capita basis in terms of investment and remission rates—any number of these—Ontario is not faring as well. Given our wealth, Ontario should be performing better than BC and Alberta and some other provinces; currently we are not.

My question to you, Minister, is this. I know you're not at the table, but will you be taking a more aggressive stance with the federal government about moving the national agenda forward so that we can get some targeted federal dollars toward our treatment programs for all Canadians but, in particular, in Ontario?

1110

Hon. Mr. Smitherman: To the contrary, it's my leadership that's going to see the national cancer strategy as an element of the agenda at the upcoming federal-provincial-territorial meeting. I'm currently the co-chair of the FPT. I had a chance to meet with representatives who are working on this strategy about seven or eight weeks ago, because I do think that it's appropriate for Ontario to play a leadership role.

I read the piece in the Globe that I think you may be referencing or paraphrasing in some ways in your question. I do think that this is an area where there is opportunity for more progress on a pan-Canadian basis. I have committed to those groups that at our upcoming FPT meeting I'd make sure that they had the chance to address all of us together. They have been working hard. I know that they've been criss-crossing the country seeking to align commitments from as many jurisdictions as possible. Accordingly, I thought it was appropriate that we show leadership and get the opportunity that they were desiring, to be able to address all of the provincial and territorial ministers at the very same time as addressing the federal minister as well.

I can't prejudge what the outcome would be, but—

Mr. Jackson: Nor would I expect you to.

Hon. Mr. Smitherman: —we'll continue to offer some leadership there.

Mr. Jackson: Thank you. Minister, earlier you referred to my reference to Helen Stevenson's review on the drug benefit program as speculative. I apologize if I speculated. The information I got was from individuals whom she has met with, relying on her assurances to them. Could you please provide for this committee the copy of the terms of reference that she is operating under, that you've contracted with her to do the review, including compensation, staffing, budgets, any consultants' contracts that are called for, approved, or under consideration, and perhaps even what the deliverables are? It's not just the terms of reference, but what the deliverables are. As a former minister, we generally try to make sure that those understandings are very clear when people are doing these kinds of independent reviews. And what would the timelines be?

My understanding, and maybe you could help me with this, is that this is not a round table type of operation, where everyone will be brought around the table to discuss this, but in fact, this is an individual research and consultation process. I'm also led to believe that there will be a draft consultation paper or a consultation paper that will be released at stage one, and then stage two will be that that will stimulate discussion, and then she will bring forward her report to you.

Those are my understandings, so if you could help me to understand that, I would appreciate it. I wasn't trying to be speculative. I've talked with people who have actually met with her, and those were the assurances she have given them, so perhaps you could help us to understand when we might see the consultation piece and maybe when you're expecting a finished product. I can't ask you when we'll see it; that's entirely up to you.

Hon. Mr. Smitherman: There's a bunch there. Any that I miss, ask me again. We're not anticipating the release of a consultation paper. What we're anticipating is that we will continue to create a dialogue with that

broad array of stakeholders who are interested in this issue by asking them more precise questions.

In your government, there was this tremendous effort—everybody got around one table and there was a lot of sawing-off, and at the end of the day—

Mr. Jackson: We met three times.

Hon. Mr. Smitherman: Yes, and at the end of the day what came forward was a little bit—it didn't exactly arrive at an easy–to-implement consensus, is about as diplomatic as I can be around that strategy.

The issues are well staked out by now. We have been pretty transparent for a long time in acknowledging that we were going to look at a bunch of stuff, and we've had the chance to talk about some of those things in the Legislature before. Her work over the course of the next several months will include lots and lots of opportunities for meetings with those stakeholders, where they will go through a variety of different scenarios with a view toward trying to improve on some of the ideas that we have developed so far. We're very, very happy in the context of the rules around FOI and the protection around personal information and all that stems from it to be able to give you the information you sought right at the beginning.

Mr. Jackson: When will she have a deliverable to you?

Hon. Mr. Smitherman: What I'm working on is the basis that we need to be implementing initiatives in keeping with our next fiscal year. That doesn't mean the end of March, therefore, because implementation is timely. I expect a lot of progress to be made around this in a period of about the next three to four months, with some action time, so the next three to six months as an overall framework for progress on these initiatives.

I'm not sure, Deputy, if there's anything that I might have missed or that you wish to add.

Mr. Jackson: So when I speculated about next spring, I wasn't too far off.

Hon. Mr. Smitherman: It was speculation with respect to the release of a consultation paper.

Mr. Jackson: Thank you. I'll anticipate receiving those and I appreciate the explanation.

With the limited time I have left, I wanted to move on to a couple of issues I want to raise with wait times that, in my view, haven't really been discussed very much in the public stream, and I'll use my own community as an example. First of all, I want to say I appreciated Hugh MacLeod's presentation a few moments ago. But out of that, is it possible for us as a committee to receive the breakout of those hospitals that have—Hugh referenced three measured outcomes that he monitored. I'm interested in hospitals that don't have a process in place to track and monitor cancelled surgeries. He identified three. Is it possible for us to have that list of hospitals?

Hon. Mr. Smitherman: I'm not understanding your question, but the deputy, I think, is getting it.

Mr. Sapsford: You mean as a result of those reports?

Mr. Jackson: As a result of those reports.

Mr. Sapsford: Yes, the reports can be made available.

Mr. Jackson: OK. The reason I raise that, Minister, is because—and I'd appreciate some limited feedback. I understand Hugh has done considerable work in BC and has addressed some of these issues. He's a welcome addition to any government's team. However, the concern I have is with the amount of doctors available to perform the surgeries. I'm going to briefly tell you my challenge in my community of Burlington. We're 150,000 people; we have three orthopaedic surgeons. Our next-door neighbour is Oakville. It has 150,000 people; it has six orthopaedic surgeons. The waiting time for hip and knee is three to four months in Oakville, but it's two years in Burlington. We appreciate very much you giving us the additional monies, and I don't need to put on the record the amount and the number of surgeries, but the problem still doesn't go away that Joseph Brant hospital independently determines the number of physicians that it requires to meet community need.

I guess my question to you is simply this: Are you, as a minister, considering looking at intervening in hospitals that staff in a manner which exacerbates waiting times? I'm not impugning a motive on the part of my hospital, but I have had very heated discussions with them about why we don't have sufficient orthopaedic surgeons in Burlington, when we could easily attract them. That's an internal decision made by the hospital, by the chief of staff in consultation with others. There is an empty surgical room at Joseph Brant. Only six of our seven operating theatres are operational. I'm going to set that aside; that's a funding issue. But it's not the government's fault that Joseph Brant hospital only has three orthopaedic surgeons. So even with your additional money, Minister, the waiting lists in Burlington for hips and knees are going to drop dramatically to a year and a half. I need help here to understand, how can government and your ministry, recognizing this problem, deal with it? Because frankly, I'll tell you, I went out and found an orthopaedic surgeon in a different community and I'm referring people. They're done routinely in three months, but I don't think that's an appropriate role or an appropriate way to look at health care, to say, "I've found you a surgeon. He's in this city. You'll get done in three months like clockwork." That's wrong.

1120

The Acting Chair: We have about one minute left.

Hon. Mr. Smitherman: There's a lot there. Let me try to hit the marks.

Firstly, you've just offered up some wait times that are anecdotal. Soon we're going to have a public wait time registry, which is updated every couple of months, that is real time and is going to give Ontarians more access to that kind of information.

The second piece is that some of the language, the way that you asked the question about the ministry—I can't remember what word you said—I'm going to use the word "foisting" itself on the hospital to improve procedures. We're trying to change culture, for sure, and adopt best practices and all of that stuff. A couple of pieces of this include, firstly, the expert panels. We're

trying to get the system to train the system about how to respond appropriately using expert panels, meaning other doctors. Not the ministry on high issuing a directive and saying, "It should be like this," but actually encouraging people and giving them the tools to work that out at the community level.

Part and parcel of this are local health integration networks. You've asked questions in a Burlington stand-alone context, in a Joe Brant context alone. But what we seek to do, as we continue to collect data on a local health integration network basis, is to make decisions around appropriate allocation of resource within those so as to create more equitable access to the resources in the province of Ontario.

We had a chance to talk about this yesterday on the Champlain district in Ottawa. They've always lagged behind on MRI and hips and knees, so we're working double time, now that we have good, quality data to back up what was long-standing anecdotal information, to actually try to address it.

I think if we could steal 30 more seconds, the deputy might want to offer a word or two as well.

The Acting Chair: Make it quick.

Mr. Sapsford: The whole human resource issue is a very important part. We are looking at it on a global basis provincially, and on the wait-time issue specifically, to begin to have these discussions with hospitals through LHINs about how we're going to serve the population in a geography as a whole. If that means we have to address issues of physician privilege and looking more globally at access to services, that's part of the intent of this overall strategy.

Just to be complete, for the member's interest, the reports that Hugh was referencing are available on the Web site right now. The MRI/CT report, the cataract report, critical care and the surgical throughput report are all there now. That will be joined shortly—I think next week—by the cancer surgical report as well. So those are available.

The Acting Chair: Ms. Martel?

Ms. Martel: Minister, I want to go back to the issue we were discussing in the last rotation, and that's the private financing of some of the hospital redevelopment. You said in your remarks that there was an important debate on this on Monday in estimates on infrastructure, and you're right about that. I'm continuing it here because I think there are some very serious implications on the health side that I want to raise.

Those implications arise because in the committee on Monday, Minister Caplan—in addition to the comments that these arrangements would be more expensive and that schools, for example, could be privatized—also made it very clear that virtually any service within a hospital could be privatized as well. He started off with a list that included maintenance, laundry, food services, cleaning, user fees for community use, portering, and ended up by saying "everything." So I'm going to assume that includes any of the programs for patient care and for patient services that are provided in a hospital.

If that's the case, there is no way that can't have an impact on one of the election promises your government made, which was to stop the creeping privatization of health care. What I see as a potential to occur is that money, then, that should go into patient care ends up having a portion being diverted to the profits of the companies that are involved in running those services, whatever they may be, in the hospital. This makes no sense to me. It, frankly, encourages or reinforces privatization in the hospital system.

My second concern is, if you look at the experience in Britain, many of the private sector consortia that were involved in the capital construction also ended up being intimately involved in the ongoing operating of the hospital, and there is certainly a great deal of evidence about what the impact was there on patient services, the provision of human resources like nurses etc. What I've seen has been very negative. I go back to this because my very clear concern, having heard what Mr. Caplan said—that virtually anything in the hospital could be up for grabs in terms of privatization—is, how does that deal with the promise that your government also clearly made, which was to stop the creeping privatization, in this case in the hospital system?

Hon. Mr. Smitherman: I think the key point that needs to made here is that there's nothing associated with any of these mechanisms that can lead a hospital to privatize a service that wasn't available to them over the last number of decades. Creeping privatization, as you've referred to it, was ongoing in the days that your party was in office, where hospitals chose to take services that heretofore had been provided by hospital employees and asked another organization to provide those services. That's not new. That's the status quo, and that's the status quo that goes back to the days when you were serving as a minister of the crown. So I'm not really clear on your question as it relates to that. I think you mentioned the issue of portering particularly.

I talked a little bit about this yesterday. There is a fair bit of private delivery of universally accessible health care services in our province already, and that has been the case under governments for quite a long time. Some governments move to increase it; some governments may not. What we've done, as an example, around repatriation of MRI and CT is to move some of those privatized services back into an environment where they're well connected to the publicly delivered system, because we want to make sure that the integration of service is not lost in that instance.

But there's nothing going on in a hospital today, nothing made possible by any financing mechanism today, that offers a new opportunity for a hospital board to decide to have that service delivered differently. There's nothing new today that wasn't there when your party was the government. There are many, many examples, I believe, of services that were privatized in hospitals during the days when your party was in office, so I'm not sure how it's different now.

Ms. Martel: I'm looking at the commitment that was made by your party before the election, which was—and

I think it's been repeated in many places—to stop the creeping privatization of health care. Your minister on Monday made it very clear that as part of this process of hospital redevelopment, as part of the contract negotiations with hospitals, not only was the financing for capital going to be privately financed but there are going to be opportunities for other consortia to be involved in a broad range of operations within the hospital. He was very clear that any and everything could be a part of that.

Now, it seems to me that having that opportunity out there clearly runs contrary to the commitment that your government made to stop privatization. Second, I think it flies in the face of evidence that is before us now from other jurisdictions that have gone to a private financing model that going beyond private sector financing into private sector delivery of services and programs in a hospital, particularly around human resources, has proven to be very negative from the perspective of patient care. The third thing that I see happening is that money that should be going into patient services and to direct delivery of care ends up being diverted, in part, to the profits of those companies that are now involved in the operation of those services.

So I don't see how, on the one hand, another minister can say that everything is on the table, that every service and every program that's in a hospital is on the table as part of this negotiation process for private sector financing, and on the other, you are trying to tell the public that your government is committed to stopping the creeping privatization. There's a contradiction there.

1130

Hon. Mr. Smitherman: Oh, no, the contradiction is on your part, I think. I'm having a really hard time understanding why you think that getting—firstly, we have community-based governance in our province. Minister Caplan was asked the question, which is a speculative question, and he answered it well, which is to say that the same rules apply now as have applied for decades. During your party's term in office, that meant that some services that were theretofore—I guess then they could have said "heretofore"—delivered by the public sector through employees of hospitals were privatized. Mr. Caplan's answer to the question just confirms that that's still the circumstance. He doesn't predict how much will take shape that way; he just says that that's still the circumstance.

If a whole bunch of hospitals in the province of Ontario have decided that it's more efficient for them to work together and to have laundry services delivered by an entity other than employees of a hospital, that they find the capacity to do that in a fashion that reduces their cost, that's good for patient care.

So I'm a little bit hard pressed to see how it is that you've made the leap to suggest that providing services through an outside provider typically, almost exclusively, to the best of my knowledge—the kind of things that Romanow referred to as ancillary services, not clinical. I don't understand how getting the private sector involved to provide those services at less cost is bad for patient care. I rather think to the contrary; it allows a hospital to preserve more resource and apply that to the important work that it does around clinical care.

Why would it be a bad thing in Ontario to say that a cafeteria—you know, it used to be civil servants who operated the cafeteria here, and it was quite good. The cafeteria that operates here is operated by a private sector company. It's very good.

Ms. Martel: You haven't been downstairs lately.

Hon. Mr. Smitherman: I have no quarrel around it.

I don't know how you would draw the conclusion that spending less on laundry is bad for patient care. I rather think that that dedicates more resources to patient care.

Ms. Martel: Two points, Minister. The cafeteria downstairs: I don't know if you know, but the recent contract involves the dropping of wages of the remaining staff by two bucks. So I'm not sure how that's beneficial to the workers who work there. That's an aside.

Your minister didn't stop at ancillary services. You're focusing on housekeeping etc. He didn't stop at ancillary services. The experience in Britain is that the government there didn't stop at ancillary services either. I think the—

Hon. Mr. Smitherman: Maybe he didn't understand the question well.

Ms. Martel: If I might—

Hon. Mr. Smitherman: None beyond ancillary services are those that are being, to the best of my knowledge, envisioned to be provided. You bring me a real-world case and I'll have a debate or a discussion with you. But this is a speculative question, and I don't—

Ms. Martel: No, it's not.

Hon. Mr. Smitherman: There's nothing that can be done now that wasn't done when the NDP was in government. Nothing changed.

Ms. Martel: No, it's not speculative. That's why I'm raising it, because it is a very important issue, and the minister didn't stop at ancillary services.

My concern, which I raise with you again, is that the experience in another jurisdiction, which I think is well documented in terms of what happened when the private sector became involved in private financing of hospitals, is that they then became very acutely involved in private sector financing of many operations in the hospital, many that dealt directly with direct patient care, and the experience was anything but satisfactory or positive.

That's exactly my concern and why I raise it here with you as the Minister of Health. If that's the experience, and the evidence is clear as to what happened when the private sector went beyond private sector financing but were involved in all aspects of the hospital, which is what your minister confirmed could be the potential—and he did not stop at ancillary services—why ever would we want to replicate that here?

Hon. Mr. Smitherman: It's entirely a speculative question, because in no hospital in Ontario, or none that has moved forward with the support of our government, has this British example that you want to keep trotting out occurred.

Look at William Osler. Let's use a real-world example, please, instead of speculating around these things.

That's one that you guys like to raise a lot. Is the private sector anticipated to be moving in to deliver services in areas beyond those which were possible and occurring when your party was in government? The answer is simple, and it's no.

Ms. Martel: We haven't seen all the details of the contract, so—

Hon. Mr. Smitherman: Well, these things have been very available for quite some time.

Ms. Martel: We had staff take a look, and since so much of it was blacked out that was supposed to be available for public disclosure, it was hard to determine exactly what they were going to have. I do remember, though, them having a liability clause with respect to who would be liable if patients were lost in the hospital, and we raised that case with you in the Legislature. So there was some very clear indication that not only were they going to be involved in the financing, but also directly involved with patients. I'd ask you to go back and take a look at that, because I very clearly remember us raising that question of why it would be necessary to protect the private sector consortium from liability with respect to missing or losing patients if indeed their only role was relegated to the financing itself.

Hon. Mr. Smitherman: Now you're making up a new argument.

Ms. Martel: No, I'm not making up a new argument.

Hon. Mr. Smitherman: I never said that the involvement of the private sector as relates to William Osler is limited to the financing. That's not what I said, and that's what you've just suggested. What I said was that the role of the private sector in the arrangement at William Osler does not do all of those things that you've said it does in your attempt to link these British circumstances. I'm just saying that therefore that is speculative.

The role of the private sector has emerged over decades around the provision of services which are not clinical in nature. That occurred under your government, it occurred under Mr. Chair's government, and it's the same set of rules that are in place now. If you want to bring me a real-world example, then I'm happy to deal with it.

Ms. Martel: Minister, I'm going to raise it again. We've raised William Osler and we raised the question in the Legislature as to why it was necessary as part of the contract to have the private sector consortium protected from liability with respect to losing a patient. If they were only involved in the cafeteria or laundry services, there would be no reason for them to come into contact with a patient in the hospital. That's clear to me, clear to you.

Hon. Mr. Smitherman: So you've decided that pushing a stretcher is the provision of a clinical service? In the Ontario health care system, we've got private—

Ms. Martel: If that's portering—

Hon. Mr. Smitherman: We've got private involvement at a far higher level—

Ms. Martel: Can I just respond to that? If that's what portering is, then your minister on Monday said that, yes, portering could be privatized. If that's what portering is in a hospital, then your minister said yes, that is a function that could be up for private sector delivery.

Hon. Mr. Smitherman: Already in the Ontario health care system in a wide variety of ways we've got private sector organizations delivering a level of clinical care that far exceeds that.

The theory that you advance, as I understand it, is that a nurse who operates for and is paid by a private company is no longer a nurse, is no longer a satisfactory person to exercise clinical judgment.

Ms. Martel: On the contrary, Minister, the experience in Britain—

Hon. Mr. Smitherman: Then why the thread around portering?

Ms. Martel: The experience in Britain was that because the nurse was paid by the private sector company and they were interested in making a profit, there was a decline in the number of nurses that were available to provide good-quality care in the hospital system, that the private sector company was not interested in staffing to an appropriate level to ensure the proper provision of health care services, particularly nursing services—

Hon. Mr. Smitherman: But the contract dictates these things.

Ms. Martel: —and that those cuts had a direct implication on patient care.

Hon. Mr. Smitherman: It seems to me you've taken about seven things and sought to weave them together in some magical concoction. The reality remains that at William Osler Health Centre, this beautiful new 1.3-million-square-foot hospital emerging in Brampton, when the people walk through the door of that hospital, it will be a community hospital and they will cherish it the way that other hospitals are cherished. The service that they are provided there will be provided as it is in any other environment in the province of Ontario, with the loving care of Ontarians providing those services. There will be nothing going on in that hospital that has not been possible under your government or under Mr. Chair's government or any other. It will be the circumstances that have been ongoing in the Ontario health care system for quite some long time.

Ms. Martel: Again I raise the case at William Osler and what we raised. And the second point that I raised earlier was that this will cost the community a whole lot more. At the end of the day, the private sector financing is going to cost both the community more, because the community share has to increase, and cost the taxpayers of Ontario more. Your minister admitted that in committee on Monday. This runs entirely contrary to the promise that your own Premier made before the last election when he admitted that these privately financed projects do cost more and he wouldn't be a part of it.

1140

Hon. Mr. Smitherman: It's the inability of my honourable friend to net out, to understand that the impact of the traditional method of financing hospitals that she so favours has resulted in the Ontario taxpayer being bludgeoned by projects ongoing in your very backyard.

It's astonishing to me that you would be so wedded to the status quo, even in recognition of the extraordinary shortcomings that have been seen there, in the absence of risk transfer, in the absence of discipline around getting projects built on time and on budget.

On this point about services, I can only repeat one more time that the honourable member, I think, would be well advised to take a look at the situation that was in occurrence when her party was in office. At the time your party was in office, what is being referred to as creeping privatization was occurring as hospitals made decisions—to the benefit of patient care, I believe—to go with the provision of services by some private sector operators in ancillary areas, because they identified that they could be done at a rate that would allow more resource to be dedicated to patient care. I think that's evidence how patient care has benefited, on laundry and on a variety of other things that are ancillary. That's the same role.

With respect to something you said, none of this information related to the provision of services at William Osler was blacked out in the contract. I think it's important to correct the record on that.

Ms. Martel: No, I'm sorry, there was a great deal of information blacked out in the contract. We had researchers who were on site—

Hon. Mr. Smitherman: Not related to the services.

Ms. Martel: —researchers who went to see the contracts and—

Hon. Mr. Smitherman: You were misled then; not related to the services.

Ms. Martel: Minister, I tell you that we went to have a look at it and there were great portions of it that were entirely blacked out.

Hon. Mr. Smitherman: You said that it was impossible to determine the range of services because that information was blacked out and I am telling you, no, that is incorrect.

The Chair: Thank you. On that note, we will request a copy and that will resolve this matter to everybody's satisfaction. You just provide a copy of the—

Hon. Mr. Smitherman: The contract is in a room and it's available for everyone. It's 7,000 pages?

Interjection.

Hon. Mr. Smitherman: Oh, 700. It's only 700. It's available, Mr. Chair. We can give evidence to the committee of where that's available.

The Chair: That's fine. That concludes this round, and by mutual agreement here, Minister, we will be pleased to have you wrap up briefly.

Hon. Mr. Smitherman: I think you'd be more pleased if I wrap up just by saying to all members of the committee, thank you. I said in my speech yesterday that I like the estimates. I'm pleased to be able to say, as I conclude my estimates' defence, that the good view I had about how fun and how important this was for Ontarians has been affirmed. It's given my sister at home the opportunity to get more exposure to me than she has in a long time, and I know she's enjoyed that. I just want to thank all the members for the interest they show every day in the health care needs of their constituents. We've addressed a broad range of subjects here today and yesterday which I think have been well-covered and I just want to thank everybody for their involvement and for welcoming me here.

The Chair: On behalf of the committee, I would like to thank you and your deputy, Ron Sapsford, and the significant number of staff who've been here, available to this committee for questioning. We appreciate that very much.

The chair recognizes that we have come close to completing our time and I'd like to proceed with the votes.

Shall vote 1401 carry? All those in favour? Opposed, if any? Carried.

Shall vote 1402 carry? All those in favour? Opposed, if any? Carried.

Shall vote 1403 carry? All those in favour? Opposed, if any? Carried.

Shall vote 1405 carry? All those in favour? Opposed, if any? Carried.

Shall vote 1406 carry? All those in favour? Opposed, if any? Carried.

Shall vote 1408 carry? All those in favour? Opposed, if any? Carried.

Shall vote 1409 carry? All those in favour? Opposed, if any? Carried.

Shall vote 1407 carry? All those in favour? Opposed, if any? Carried.

Shall the estimates of the Ministry of Health and Long-Term Care carry? All those in favour? Opposed, if any? It 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.

I will now declare a recess until 12:30 of the clock, at which time we will proceed and commence with the estimates of the Ministry of Children and Youth Services.

The committee recessed from 1145 to 1233.

MINISTRY OF CHILDREN AND YOUTH SERVICES

The Chair: Good afternoon. I'd like to welcome everyone for the commencement of the meeting of the standing committee on estimates. We are convened for seven and a half hours to undertake the Ministry of Children and Youth Services. I'm pleased to welcome the Minister, the Honourable Mary Anne Chambers and, I believe, her deputy as well, Judith Wright.

Minister, you have up to 30 minutes for your opening statement. We're in your hands.

Hon. Mary Anne V. Chambers (Minister of Children and Youth Services): Mr. Chair and members of the committee, as the recently appointed Minister of Children and Youth Services, I am pleased to appear before you today. Our government's plan is to strengthen our province by strengthening our people. As part of that plan, Premier McGuinty has given me the opportunity to

make a real difference in the lives of our children and youth through this vitally important portfolio.

We're helping give them the best opportunities to be successful in school and in life. This ministry not only provides care and support for our children from their infancy through to their teenage years, we also help to support parents and caregivers as they take on the all-important job of raising a child. We do that by looking at all of our programs and services from the vantage point of the children and youth we serve. The Ministry of Children and Youth Services also plays a key role in the prosperity of this province and this country. It brings together the key priorities of our government: health, education and economic well-being.

I am pleased to be joined today by a dedicated group of people: My brand new Deputy Minister of Children and Youth Services, Judith Wright, and my senior ministry staff. Before I tell you, though, about the ministry's ambitious plans, let me first tell you just a little bit about my own background.

You could say my own life has had three pillars: family, career and community service. My family consists of my husband, our two sons and two lovely granddaughters, aged seven and five. Just thinking about my remarks before coming in here just now, I recall—I don't often think about this, and yet I know it influences a lot of what I do: My older son, I'm proud to say, worked his way through high school and university, working with children and youth with special needs, with very severe challenges that included degenerative-type conditions and autism. I have to tell you, even just thinking about it, I still think about how wonderful it is that we have such caring and special people who do this kind of work. I'm proud that he's my son. My other son, actually, works in the justice system. The Premier doesn't know all of this, and yet I get this portfolio. I think there is something here to do with providence.

Prior to holding public office, I had a long and rewarding career in banking. I worked for Scotiabank for 26 years. At the same time, I've helped serve my community through a number of highly respected organizations, including the United Way of Canada and the United Way of Greater Toronto, the University of Toronto, the Rouge Valley Health System with hospitals in Scarborough and Ajax-Pickering, and the Air Cadet League of Canada, a very well respected youth organization. I also support a basic school for young children, and a home for severely disabled young people in Jamaica, which is where I was born and raised.

Having entered public life, I've found that the values that guided me in those years of my life continue to influence my thinking and continue to help me as I deal with the very difficult challenges and important opportunities that exist in government. In my previous role as Minister of Training, Colleges and Universities, I brought in the largest multi-year investment in post-secondary education in 40 years, and the most substantial improvements to student assistant in almost 30 years. This investment is a vital step in helping our young people achieve their potential and a sound financial investment in Ontario's prosperity.

In the Ministry of Children and Youth Services, our goals are very much the same. I'm committed to working with Ontario families to strengthen the services we all rely on, so that Ontario's children have the very best opportunities to succeed and Ontario has the best opportunity to prosper. Our goal is to provide a continuum of services, starting even before a child is born—services to pregnant mothers and families—right through a child's teenage years.

In effect, my work for the last two years has come full circle. Before, I was tasked with providing the opportunities students need to succeed as they reach adulthood. Now I'm setting a path for our young children so they can take advantage of the opportunities that await them. I remember doing our Best Start announcement in July, looking at these little ones in the child care centre and sort of seeing them as university and college students and apprentices in the skilled trades, my staff having to remind me that I had changed portfolios.

That, to me, is the very core of what our government's role must be. We must work to ensure that all our citizens, young and old, have the opportunities they deserve to live as full and vibrant a life as possible.

1240

At the Ministry of Children and Youth Services, we are already making significant progress down this road. We are transforming and improving the sectors that help our children and youth, including child care, early childhood development programs, child protection, children with special needs, aboriginal children and youth, residential services and youth justice.

My ministry is only two years old but it speaks to our government's determination to provide children and youth with the support they need to achieve their full potential. I have already seen evidence that supports the importance of policies that will help to ensure that children from disadvantaged families—children with mental health challenges, children whose circumstances result in child protection interventions, children with any of the many special needs that we are seeing—do not, for example, show up in our youth justice system due to inadequate support and intervention earlier in their lives. That's why our Best Start plan, for example, is so important.

We've called that initiative Best Start because we want to help give Ontario's children the very best start in life. Together with our federal and municipal partners, we have an ambitious goal: to help our children arrive in grade 1 ready and eager to achieve success.

Early intervention initiatives are designed to find those children and families who need extra support early, so that we can get them the help they need sooner. That's why we have strengthened Healthy Babies, Healthy Children, including aboriginal Healthy Babies, Healthy Children, infant hearing, as well as preschool speech and language programs. At its core, Best Start involves a massive expansion of quality and affordable early

learning and child care and an investment in the healthy early development of Ontario children, all in a convenient and easily accessible location for parents.

Let me take you through some of the key components of Best Start. This past summer, I was pleased to announce that our province is delivering approximately $1.1 billion in federal funds to municipalities over three years, beginning this year. Our plan will create approximately 25,000 new licensed child care spaces by April 2008. That's about a 20% increase in three years, and that's in addition to the investment in 4,000 new subsidized child care spaces across Ontario last year so that more lower-income families can find quality, affordable child care in their communities.

Our plan also relieves municipalities of cost sharing for the new federal funds for child care. This will save municipalities more than $208 million over the next three years, beginning in this year. This rapid expansion of child care spaces will be directed with a priority on quality child care for children in junior and senior kindergarten.

To improve the quality of our child care, we are proposing to introduce legislation that would, if passed, establish a college of early childhood educators that would set out professional qualifications and standards. As well, an expert panel is developing a preschool learning program that links directly to junior and senior kindergarten.

Our investment also supports a gradual expansion of child care spaces for younger children, because we want to make child care available and affordable to more families. That's why we've also eliminated the restrictions on child care subsidies for parents with RRSPs and RESPs. We believe that saving for a child's future should not hinder a parent's ability to care for that child in the present. We're also designing a new model for determining eligibility for subsidies based on income. This new model will make child care more affordable for more families.

As part of Best Start, we are screening newborn children to identify any potential concerns, needs or risk factors. Those families who need extra support will receive follow-up visits in their homes and referrals to other supports in their community.

By strengthening infant hearing, as well as speech and language programs, we are identifying, treating and supporting children with communication disorders, because we know that late literacy and language skills are a significant risk factor for many problems down the road.

As well, we are working with an expert panel to develop a comprehensive checkup for babies at 18 months. Early diagnosis and treatment are fundamental to helping our children get a healthy start.

We're also working with the Ministry of Education to help students develop better eating habits so they are more focused in class. We want to ensure students are getting the healthy breakfast they need to start the day ready to learn. I'll be making an announcement about this program in the very near future.

There are a few communities that are already working at an accelerated pace in implementing Best Start. The district of Timiskaming in northeastern Ontario, with its large francophone community, the rural areas of Lambton and Kent in southwestern Ontario and Hamilton's urban east end are all implementing the full Best Start vision at an accelerated pace. All three communities are working to integrate local services. They are working quickly to have their programs up and running, and we will be closely following the progress of these model communities.

In outlining the highlights of our Best Start plan, I hope I have positioned it as a socially responsible model that will serve our children over the long term. But we also need to be satisfied that our investment delivers results. We are taking steps to monitor how our investment in early development is helping children and families.

Here is one example: An assessment tool—the early development instrument—is being implemented across the province at the community level to determine children's readiness to learn at school. The results will help communities address the needs of their families and their children. The tool will also show us how our investment dollars are achieving the intended results in helping prepare children so they are ready to learn in grade 1.

I said earlier that Best Start was the foundation of some historic changes that we are making in the Ministry of Children and Youth Services, but it is by no means the only area where change is taking place. We are also making significant changes to our child protection system to help children who have been abused or neglected become successful members of our community.

We know that children who are adopted often do very well because of the permanence and security that comes with being part of a loving, stable family. However, adoption is an option that is used in only a small number of cases. We are committed to helping more children and youth find permanent, stable and supportive homes.

This spring, we introduced legislation that would, if passed, make adoption more flexible so a child can be adopted and still keep important ties to their birth family and community, and create more legal options beyond traditional adoption so children and youth can be placed in the permanent home of a relative, a member of their community or a long-time foster parent.

As well, we are making the process consistent for adoptive parents by simplifying the adoption process and supporting families after an adoption, and creating a province-wide registry to help match available children with prospective parents.

We are taking these steps because it is in the best interests of some of our most vulnerable children and youth. But it's also the responsible course.

On the fiscal side, the ministry provides funding to 53 children's aid societies for child protection through transfer payments. Last year, the province spent approximately $1.2 billion on child protection. This year, we're planning to spend just over $100 million more than last year's budget.

The demand for child protection services in Ontario has been growing since the early 1990s. Some of our children's aid societies are in deficit positions. We are working with them to address that. Our children's aid societies need to be both sustainable and accountable so they can be there for children who need them.

To help more children's aid societies, we are taking three important steps to change the way they operate:

Step 1: This year we began providing funding under a new model that puts a greater emphasis on the specific results we want to see for children, like more adoptions.

Step 2: Societies will have more options available to them when they respond to new cases. Without compromising a child's safety, societies will be better able to match their level of response to the needs of the child.

Step 3: Legislative changes, if passed, should result in more extensive use of mediation to resolve child protection matters. This is not only more effective for children and families, it is more efficient for our family courts.

1250

I would like to turn now to the topic of children with special needs, first to children and families who are living with the stressful and distressing challenges associated with autism spectrum disorder. Our government has moved quickly to make meaningful new supports available to these children and their parents. There are now more services available to children with autism than ever before. I have directed regional autism providers to address all referrals in a consistent manner. These children are being assessed, and this will assist in determining what services will be appropriate.

The demand for services continues to grow. This is having an impact on waiting lists, and it puts a tremendous strain on the resources we have to help support children with special needs and their families. However, we are making progress. Last year, we spent an additional $24.5 million to expand the range of services for children and youth with autism—an increase of 58% over the previous year. This increased investment is already delivering more services to families across the province.

We now have a program to assist school-aged children and youth with autism spectrum disorder. Through our new school support program, we hired more than 160 autism spectrum disorder consultants to work with school boards and help teachers develop the skills they need to understand and respond to a child's needs, and we are growing those numbers.

In addition, we doubled the number of transition coordinators from 13 to 26. These coordinators help children with autism move smoothly into school. And we reduced the number of children waiting for assessments by 79% as of the end of June. We expanded our existing program by hiring 110 additional therapists, and are now providing services to 39% more children with autism.

I know that while we have made progress, there is much more to be done.

In my previous role as Minister of Training, Colleges and Universities, I was pleased to work with the Minister of Children and Youth Services to establish a new college-level certificate program in autism and behavioural science. This program will help build the long-term capacity of the autism intervention program in the broader field of autism. This fall, approximately 100 new students are enrolled in the program, with the first cohort scheduled to graduate in the spring of 2006. By 2008-09, we expect that approximately 200 students will be enrolled in that program.

We are continuously looking to improve the way services are delivered to children and youth as they continue to learn and grow and as their needs change. Our vision is to deliver a continuum of services and supports that are appropriate to a child's developmental stage and help these children as they grow and learn.

On the fiscal side, the Provincial Auditor told us that we needed to move prudently and responsibly as we expanded our autism spending, and we agree. We are planning very carefully as we establish our new school-based program so that all funds are used responsibly. The new school support system established in September 2004 was just ramping up last year. All unspent funds from the autism program were redirected to the child protection system. Those funds helped Ontario's 53 children's aid societies provide services for the many thousands of vulnerable children and youth in their care.

We are also addressing other concerns raised by the auditor. To ensure autism programs are managed effectively, my ministry regularly meets and shares information between regional providers. We continue to improve our information systems so that we have better data, and we have conducted training sessions so that our staff and regional providers know what information we need. We are actively pursuing ways to improve and build on the services we provide for children and youth with autism.

Another report with which you would be familiar is the Ombudsman's report on children with complex special needs. We immediately directed children's aid societies to enable families to regain custody of their children with complex multiple special needs if the children had entered care only as a way to get services and where no protection issues existed. New investments totalling more than $100 million—that's more than a 15% increase since 2003-04—are already providing more services through children's treatment centres, children and youth mental health, and autism programs.

We're also working diligently in the area of children and youth mental health. We believe that a child's healthy development is key to their future success. Our government has demonstrated its commitment to supporting these young people by providing a big boost to children and youth mental health services in this province. As part of our new investments, our government increased funding for children and youth mental health by $25 million last year, growing to $38 million starting this year. This funding is helping create more than 100 new programs and expanding more than 90 existing programs. As well, it is helping our community

agencies to recruit and retain staff. These programs are helping communities respond to the unique mental health needs of their children and youth. The provincial Centre of Excellence for Child and Youth Mental Health at the Children's Hospital of Eastern Ontario, established this year, is working quickly to improve how mental health services are delivered to children and youth.

Along with Children's Mental Health Ontario, my ministry is meeting with young people, families and service providers this fall to develop a children and youth mental health policy framework. As well, we are examining residential services across a number of sectors, including youth justice, child protection, mental health and special needs. This will provide us with valuable information that will help us strengthen the current system of residential licensing and services.

Before I close, I'd like to address our commitments to youth justice. Our government transferred responsibility for youth justice services to the Ministry of Children and Youth Services in April 2004. This transfer recognized that most youth who are in trouble with the law have needs that are very different from adult offenders. The Youth Criminal Justice Act introduced by the federal government in the spring of 2003 has placed greater emphasis on diversion and rehabilitative interventions for less serious offences. We are committed to supporting strong, safe and vital communities in Ontario by holding youth in conflict with the law responsible for their actions.

At the same time, we are providing young people with meaningful rehabilitation to help them become productive citizens and to reduce recidivism. This strategy more appropriately balances the use of custody with community-based programs and services. We are creating programs and services which address the factors that contribute to offending in the first place. We're maximizing the potential for youth rehabilitation. We are helping to reduce reoffending rates, and enabling youth in trouble with the law to become positive contributors to their communities.

This year, we're investing in community-based alternatives to custody to provide structure and supervised programs to low-risk youth, addressing the behaviours that bring youth in conflict with the law. We want to support youth to make better decisions and accept responsibility for their actions and develop anger management, learning, employment and other life skills. Our commitment to rehabilitating youth also extends to those young people who are in more serious trouble. Last year, the government announced it would build a new state-of-the-art GTA youth centre in the Toronto area to replace the now closed Toronto Youth Assessment Centre, an older centre that was deemed unsuitable for youth. The new facility will include smaller units, better supervision and on-site classrooms and rehabilitation services.

This year, we also announced a new 16-bed youth centre in Sault Ste. Marie. In all our efforts, we are working to develop a completely separate youth justice system with an aim to reducing crime and building a stronger and safer Ontario.

1300

In ending my formal remarks, I hope I have been able to provide you with a sense of the important work that is being done in the ministry to benefit Ontario's children and youth and the significant changes that are taking place to improve how we serve those families.

The creation of the Ministry of Children and Youth Services was not something that was entered into lightly. It was created because this government wants to give priority to the needs, the strengths and the potential of Ontario's children and youth. We believe that investments in our youngest citizens are important investments in the future of this province, because through those investments we are giving them the opportunity to achieve their potential.

Mr. Chair, I would now welcome the opportunity to respond to the questions of the committee.

The Chair: Thank you very much, Minister. We have an opportunity for statements or questions or whatever for up to 30 minutes for the official opposition, and then I'll recognize the third party. I'm recognizing Mr. O'Toole.

Mr. O'Toole: Thank you very much, Minister. It's a pleasure to see you in the ministry. You certainly bring, as you described in your opening remarks, a very good attitude toward children and youth, as well as the family. As you've described it, I couldn't support it more. I did take note of a couple of things. Our actual critic is Mrs. Munro. I'm just sort of opening the remarks and welcoming you.

Really, I see two or three issues. This is often a very controversial ministry because it deals with youth and different approaches for dealing with that issue. I'm sure there's no perfect solution or we'd already be there in civilization. But certainly the adoption issue—Bill 183 has had its challenges in terms of how to implement it. Certainly Ms. Pupatello has made it clear that there are going to be no exceptions in the final drafting or final passage of that bill.

In our own day-to-day work in the constituency office, fragile families—let's put it that way—through family law or other aspects find themselves quite lost in the maze, and I think this whole idea of a continuum of service is a particularly good idea. These are just general comments, and ultimately I'm sure Mrs. Munro and others will have some questions.

But in our day-to-day work in the constituency office, first of all, I find the children's aid societies kind of removed. I know the work they deal with is rather proprietary in terms of privacy issues and other issues; it's very personal information. But I find it's almost like I'm on turf that I shouldn't be on, even though I've been asked or engaged to be because of some constituent's needs. It's almost like dealing with another country. I don't say that critically. I just find that they're protective almost to a fault. We don't go looking for trouble. We don't. We have enough work to do without digging up some spurious little piece of information. But I do encourage a perhaps more open relationship. In Durham

region, where I come from—I served on Durham regional council and I'm somewhat familiar with the health and social services issues. I hear of a couple of issues there, that we get a lot of children coming in from other jurisdictions and putting a lot of stress on an already stressed sector. As you said, some of them have deficits; I think Durham does as well. The meetings should be more so that we at least understand and know the difficulties in the broad policy sense that they're dealing with. The specifics I don't have any need to know, really, except that if pressed, there needs to be a process to resolve those differences on custody visitation. I have a couple of specific cases—I would never, ever, here in this forum, mention names—but I'm sure all members have those. It's no criticism of you. It's just bringing it to your attention.

I do want to put on the record that I want to work with them in a productive way, not to be critical, but to understand what their stresses are: "We need more money. We need more case management. We need more systems," blah, blah, blah, and "We need balanced funding on some caseload basis." It's hard to measure all that stuff because of these various cases, some more complex than others.

The other issue that I want to mention just generally, which I'm sure Mrs. Munro and perhaps others from other parties will, is the whole issue of autism and the auditor's report. It's certainly a huge issue. I have over the summer, as many members have, I'm sure, met with the autism society and tried to lend understanding, not just for the political battle, but in some respects to help the Premier, because he knows not what he says. When he wrote the letter to those vulnerable parents before the election, promising to do everything, I think now, as minister, you probably know he promised something he couldn't deliver.

It's not the promise-breaking issue that I'm pushing here. What I am saying is that in elected and public office, if we don't know, we should admit it, and if we admit that we don't know, then I think we're doing a better service to the public—any of us, whether it's provincial, municipal, whatever— as opposed to making random promises.

But on the autism file: I served as a school trustee some years ago; in fact, it was in 1982, when the special education legislation actually came into force. I was chair of the special-ed committee for the board and got to know quite a bit about the special-needs file. I don't think people identified everything as they do today: specific ADHD and all these various terms. We're becoming more clinical in the terminology we use. Having been involved and having a sister who is now retired but involved directly in this as a speech and language pathologist—she has always said that this integration issue is very difficult, that integrating all special-needs at all times in the classroom is very difficult. It's not popular to say that, but the needs are so special that they become problematic for the service provider, i.e., the teacher in the classroom.

When it comes to this bridge between the preschool and the identification process specifically in the school, the IPRC, the identification process review committee, it gets a bit techie, because they often take a year or two to identify all this stuff, and by the time they're in grade 3, they're kind of moving out of primary. The primary grades are under a lot of stress right now, big time. My wife is a primary teacher. She has 24 kids, not 20. There aren't 20 in any of the classes in her school. We heard yesterday, on a program I was on, calls from parents, as well as educators, that that 20 number is just a number.

Boards in that case need two things. They need flexibility. When there are really high special needs, 20 is not the number. And they need flexibility between you and your bridge with education and the services you provide, specifically for JK and this early childhood initiative you're following through on, the whole daycare issue. I can see it becoming even more challenging, because I'm told it's one in 10, maybe even higher, maybe one in seven, who has a special need.

So it's not just the autism file that I bring to your attention. This is fundamental to the challenges to the family, and it spins off into multiple directions for the family itself and the child's welfare in the broadest sense.

But the second thing in this autism challenge—and I see it not just in this; I see it in the health care piece in the classroom for children with special physical needs: auditory needs, visual needs, medical needs, being ventilated in the classroom and stuff like that. I don't think it should be out of sight and out of mind. All of us in society need to be aware of these things, and I'm all for that integration model. But there has to be some practical respect for the ongoing business of the school as well, and the teachers' administrative challenges.

In many cases, the service providers who come into the school to teach the teacher—we're paying big bucks for these people to come in and do these various things for a teacher who has one student. Actually, it's a union issue. My wife and my daughters are teachers, so I'm not bashing. They've got to let professionals, in those specific areas, who are trained specifically to perform the function in the class or in the school. Do you understand? They can't. It's against the contract. They can't actually do the service they're trained to do, the psychologists or whatever they are, in the school environment. It's sort of like, "We'll go in and we'll the teach the teacher" model. I'd just put that to you without getting too animated about it, but I think what we say isn't the reality at all. The teacher is left hanging by the thumbs with a limited, one-day teach-the-teacher exercise or a PD day where they're getting some general tools or skills to deal with the issue in the classroom. That's where it's manifesting, this acting out in the classroom. I know classroom management is a big issue, and a lot of it is because of these behavioural kinds of issues.

There are three small things—adoption, CAS and autism—that I've taken the time to bring to your attention that I'm sure will come up in some detail in the questions to look at the estimates.

I'd ask Ms. Munro if she would like to bring more substance to it as opposed to words.

1310

The Chair: Mrs. Munro.

Mrs. Julia Munro (York North): Thank you very much for giving us the kind of overview that you have on a ministry that on the one hand appears to be innocuously simple—children and youth—and on the other hand extraordinarily complex when you're trying to deal with the variety of issues that obviously are critical ones for the development of our young people.

I have a number of areas that I'd like to touch on and would just at this point give a little bit of editorial comment, if you like, with the idea that in the rotations later I would use those as a formulation for specific questions.

I think both we in our role as opposition as well as the general public are really keen to know about some of the details with regard to the child care initiatives that the government has indicated that it is undertaking. Obviously, the question of setting a target of 25,000 by April 2008 begs all kinds of questions in terms of the manner in which that might be done.

The other area that I think people are particularly concerned about is the question—in your own speech you referred to the 4,000 new subsidized child care spaces. Certainly reflecting some comments made by constituents of mine would be, what kind of definition are we looking at here, the threshold, for any kind of subsidized child care spaces?

The other thing that falls out from that is, I guess one needs to have a sense of the overall vision of the government in relation to the children who are in private, informal and, believe it or not, with their own mothers and fathers, this new expanded role for daycare. I think even the whole issue around creating a college of early childhood educators kind of imposes the notion that these will be the people who have the monopoly on the right way to go in raising children. We need to have a better understanding of this scheme in the context of the fact that there are always going to be children in their own homes and in informal settings.

The other thing is that you made reference, as part of the Best Start programming building on the Healthy Babies initiative, begun obviously by our government, to identify potential concerns. I'm curious to know what kinds of additional identification you are able to make beyond those that are already made, and again, in the whole context of child care, the initiative on a comprehensive checkup by 18 months. A question that I would just pose rhetorically at this point is simply, would it be the intention of that kind of checkup to identify autism, for instance? Is that a possibility? Is that what is contemplated on that issue? I think that having the whole initiative working in the communities that you've identified obviously gives you an opportunity to have a look at what emerges from doing it in communities that reflect a different demographic. That would seem to me to be an important thing to do.

I would just raise some issues with regard to what lies ahead for people in that particular area. The information that you made reference to in the area of child protection: I think that as a community, as a province, moving from a legislative framework which originally only dealt with abuse put us significantly ahead, frankly, when we added neglect to that. But at the same time, we obviously have to be looking at some of the ramifications of that.

In your comments on adoption, again, a rhetorical question that I'll ask later is the question of the introduction of the legislation that was made in the spring. It talked about, it certainly hinted at, the more flexible arrangement that you've spoken of here. I guess my question would be, where else is this being done? What kind of base do we have to consider legislation such as this, which is really, I believe, quite a radical departure from what has historically always been the role between a birth mother and an adopting family? That's a huge change in maintaining those relationships, so I think we certainly need to know what kinds of ramifications and of evidence there are from other jurisdictions.

Could you give me an idea of how much time I have?

The Chair: It's 14 minutes.

Mrs. Munro: OK; lots. I didn't know how quickly I had to move along in this.

When you're talking about the demand for child protection services in Ontario growing, and I'm assuming that part of that comes from the legislative changes that have been made, to me it would be important to know what kinds of initiatives are contemplated that would look at how to reduce that demand. I see that not only from, obviously, a fiscal point of view, because we do know that the children's aid societies have been under enormous fiscal pressure, but also obviously, at the end of the day these are children who are going to benefit from better protection services. That's why these agencies exist. So it's a question not only of fiscal, but from the perspective of how we can reduce the kind of pressures that lead children into that kind of situation.

You mentioned, in helping children's aid societies, that you want to put funding under a new model that puts a greater emphasis on specific results we want to see for children, like more adoptions. I guess that sort of winds back to that issue for me, in terms of making a more flexible arrangement in the proposed legislation and what kind of evidence we have that supports that in fact that kind of a relationship is likely to encourage more adoptions, not fewer, because obviously that's extremely important.

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The issues around autism: There have been a couple of references made to the auditor's report. I certainly want to come back to that issue in later rounds because I think it's clear that the government has spent money, but all of us as MPPs know that there's enormous angst in the community. Whether it's on the issue of the broken promise, it's frankly as much on the issue of the children under six being served and the kind of waiting lists and what appears to be lack of understanding on the part of parents in terms of communication with the agencies. I do want to come back to that specific area because I think that this provides an opportunity to look at what those

specific outstanding issues are and the way in which they are being directed.

I'm also interested in the additional hiring, for the school system, of disorder consultants. I have to say that knowing the work that was done with regard to establishing programs at the community college level for therapists, I would also want to know something of the expertise, and the academic expertise, of these people, given that we had to start from the ground up on providing the number of technicians and therapists on the issue of the hiring, which you also make reference to here.

So there are many questions that I think both we and the public need to have answered in terms of the progress you have made since the auditor's report last year.

You mentioned later the importance of children and youth mental health and the increasing of funding and the challenges with regard to recruitment and retention. I think this is an area that is particularly important to us as we move forward because of the fact that, as more and more diagnosis and greater expertise is available in that area, obviously it's got to be matched with the kind of people who can come forward to provide the support for these children.

I've tried to highlight the particular areas you have referenced just to give you a kind of overview of the concerns that I have on this, so I look forward to the opportunity to be more specific and be able to then address specifically those questions in the areas I've identified. Thank you.

The Chair: Thank you, Ms. Munro. I would now like to move to Ms. Horwath.

Ms. Andrea Horwath (Hamilton East): I wanted to start off by saying congratulations to the minister for her new portfolio and also to say how pleased I am to be critic in this area and to let you all know this is my first time at estimates, to actually do some of the estimates work. I'm thrilled to be able to have that opportunity as well. What I'd like to do, if it's all right with you, Mr. Chairman and committee, is maybe do a brief overview of the things I'd like to be touching on, and then if that's not a problem, go straight into some of the actual questions I have for the minister, for a couple of reasons, not the least of which is that we have some people here today who are quite interested in a particular area who might not be able to join us tomorrow. I thought that might be the best thing to do, get some of those issues on the table and aired, if that's alright.

I'm going to talk a little bit, first of all, about what we've seen happening with changes to the ministry and what I suspect that might be meaning. I wanted to talk a little bit about special-needs agreements and I'll be asking some significant questions in that particular area, because as we all know, that has been in the public light only because of a lot of work by some very determined and courageous parents, and then, as well, some response from the Ombudsman. So I'd like to spend a significant amount of time on that this afternoon.

That follows naturally into the issues of the autism and IBI file. I'll be asking some things about that. Then I'll likely move into some of the early learning and care piece of the portfolio, because I think that there are some specific questions about how that's rolling out and how we will see some accountability in that system over the next couple of years. Finally, I will be touching on some of the issues around children's aid societies, child protection, and children's mental health. It's quite a large number of areas to discuss. Again, I think it was Ms. Munro who said it seems like such an innocuous kind of title for a ministry, but as we can tell just by this brief overview—and I haven't even touched on some of the other issues—it's a significant ministry in terms of responsibilities and in fact expectations, not only by those of us around the table but by families and children in communities across the province.

I did start off by saying that I congratulate the minister on this new portfolio of hers, but I'm wondering why this shift came about at this point in time. I would suspect that a part of the shift is the result of the previous minister simply dropping the ball on a number of these issues and the need for the government to re-focus the priorities and make sure that some of the problematic areas were being addressed. One of the pieces that I didn't see in the opening remarks of the minister that was raised by the previous minister was that of the independent child advocate. That wasn't raised in the opening remarks of the minister. I know that back in March, Minister Bountrogianni, when she was minister of this ministry, said that, "the McGuinty government will introduce legislation this spring that, if passed, would better protect the interests of vulnerable children and youth by establishing an independent child advocate in Ontario." As far as I recall, we haven't seen that legislation yet. I don't think it was mentioned in the remarks by the minister. Maybe I could ask the minister if that's still on the agenda or if that's one of the changes.

The Chair: Minister?

Hon. Mrs. Chambers: Thank you, Chairman, and thanks to committee members for the comments made so far. To this specific question on the independent child advocate, that is indeed on the table. In fact, the current child advocate, Judy Finlay, is one of the first people I met with. What we are doing right now is benefiting from her input into what we are doing. She has been the child advocate for 15 years. She has done an incredible job. I felt that it was important to get this right and I am very pleased to have had the opportunity to spend a fair amount of time with her so far. I'm aware of some of the issues that she would like to ensure are reflected in the submission that we are working on. I think we're really close, but you will agree that it's really important to get this right. I'm committed to getting this right.

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Ms. Horwath: Then is it fair to ask, will it be right by the fall? Will it be right by winter? Will it be right by next spring?

Hon. Mrs. Chambers: It is a priority item.

Ms. Horwath: So you're not prepared to give a guesstimate of when you expect that legislation will come forward?

Hon. Mrs. Chambers: We're working on it as a priority item, but, as you know—

Ms. Horwath: You don't want to make any promises that you might have to break.

Hon. Mrs. Chambers: Well, I don't actually determine the legislative schedule.

Ms. Horwath: That's true.

Hon. Mrs. Chambers: So you wouldn't want me to do that.

Ms. Horwath: OK. I'll leave that one aside, then, and I think that response is extremely important.

Hon. Mrs. Chambers: You have my commitment that it is indeed a front-burner item. It's very important. It has actually been on my desk, OK? So it is a priority item.

Ms. Horwath: Very good. I'm glad to hear that, because we were wondering whether—when I didn't see it in the speech, I got a little nervous and thought that maybe it had fallen off.

Hon. Mrs. Chambers: There's a lot more that I could have said.

Ms. Horwath: That's true. That's great. Thanks very much.

I guess the other general question about what's happening within the ministry is that we've noticed there have been a couple of changes within the high-level staff in the bureaucracy. I'm just trying to figure out—we've had a change in the program manager, the assistant deputy minister for the Ministry of Children and Youth Services and the Ministry of Community and Social Services. I believe we have "acting" involved there. Cynthia Lees is gone from that portfolio. Is that right? As well, there's a change in the strategic policy and planning position.

I'm just wondering: These two positions seem to be fairly key. Is there a particular reason why these people left? Is there a shift in the direction of the ministry such that they could no longer stay, is there some other major change that has occurred or is it simply—can you explain to me if there has been some major shift in the way the ministry is moving that has caused these staff changes to occur, at the same time as the minister has changed as well?

Hon. Mrs. Chambers: Well, some of those changes actually occurred before the minister was changed, and there have been moves since I have been given responsibility for this ministry.

I think it's fair to say that for a ministry that's two years old, it's a brand new ministry. Having said that, it's not a ministry with a portfolio that has started from scratch. There are challenges to both those types of scenarios or those types of situations. If it had been a ministry that had started from scratch, I guess we could be at this stage struggling to even identify what the scope of the portfolio should be. Given that it is a ministry that is new but did not start from scratch, we are actually in the throes of ensuring that the ministry works as effectively as it can, given that at the end of 2003, in the fall of 2003, there were pieces that came over from community safety; there were pieces that came over—in fact, youth justice came in April 2004, even later than some of the other pieces. So we have been pulling together community safety, community and social services, health, and some education stuff. We're still working on fine-tuning whether or not there are other things that should come to this ministry.

I think it's fair to say that it should be recognized that the delivery of support to stakeholders does not appear to have been interrupted by this move. Having said that, I think it's fair to recognize that we have a second round of activities that must take place to ensure that we are in fact running on all cylinders.

An example would be, consistent with my vision and the vision of the Premier and of senior ministry officials, that we now have to be sure that our focus centres on the child and youth. So we look on the different files and we see connections, unfortunately. I alluded to that in my remarks. We actually see a need to ensure that we not only invest in our kids at the earliest possible opportunity, but that we also recognize that there are child and youth mental health challenges that will affect, for example, who might end up requiring protection or who might end up in youth justice.

We know that there are too many young people in the youth justice system who in fact were first seen in child welfare. This is an opportunity in this new ministry to not view that child or youth as a different person in the child welfare system from the person who, unfortunately, ends up in youth justice. If we reorganize our thinking and focus on a vision that sees this child or this young person from the day they arrive in our sphere of care through to where they can succeed on their own, then I think we will really be doing a good job. We're working toward getting there.

The Chair: Thank you, Minister. You did raise a point that your organizational chart has changed since you've become minister. Could you supply the committee with any changes to that?

Ms. Judith Wright: Yes we can, Chair. The actual organizational chart hasn't changed but, as Ms. Horwath said, there's been a change of personnel, not the least of which is me.

The Chair: So if you can enumerate all of that, that would be appreciated.

Ms. Wright: Shall do. We'll get you that tomorrow.

The Chair: Thank you. Ms. Horwath, you have the floor back.

Ms. Horwath: Thank you for that response. You might not consider that a change of direction, but I found it interesting because you're focusing on being different from the last minister, who spoke mostly only about Best Start. So that actually is a considerable change—in my opinion, anyway.

I have with me today Cynthia Cameron. People might know or remember Cynthia as a woman who was dealing with some very serious challenges with her son, Jesse. Cynthia, at that time, lived in London. Unfortunately, because those problems have not been addressed, she's

moved to Toronto. Well, I don't know if it's unfortunate that she moved to Toronto, but she now lives in Toronto because her son was still very far away from his family. Cynthia did come today because, unfortunately, there are still some major problems with what's happening with special-needs agreements and with those very families that the Ombudsman outlined in his report.

In the May report of André Marin, the condemnation of the previous ministry was palpable. Throughout his report, he made a couple of assertions that I had written in my remarks. I'm going to read them out, because they were reflected again in what the minister said in her opening remarks today.

In his review of the real crisis that was being faced by families with children with special needs, he said that the minister and ministry did little more than provide the "ultimate in bureaucratic responses" and in a most despicable fashion used nothing but weasel words to put off taking any responsibility for dealing with that crisis. Instead, they were "examining the spectrum of residential services," and six and a half months later they were still "undertaking a review of the spectrum of residential services." And almost a year and a half after that, unbelievably, they had made a decision to once again "examine the broader children's residential system." Unfortunately, this morning, on page 12 of the written copy of the minister's speech in regard to children with special needs, she said, "As well, we are examining residential services across a number of sectors." This is, yet again, five or six months later; these words were first mentioned years ago on this particular file.

Minister, I'm a little bit concerned about whether or not what the Ombudsman called creating "the illusion of progress while nothing concrete was being done" is going to continue under your leadership. I guess it's pretty straight out to ask you whether you feel, as the minister who's been responsible just for a couple of months now, that you've actually fixed the problems that were outlined in the Ombudsman's report.

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Hon. Mrs. Chambers: On the subject of residential services and the review, I can in fact give you a date when the report is supposed to be delivered to us: December 2005, so that's this year.

With regard to the Ombudsman, the Ombudsman was also one of the first people I met with, because I take him very seriously, I take the issues that he raised very seriously, and, quite frankly, I agreed with a lot of what he had to say. I am pleased that he seems to be happy with the progress we are making.

On the matter of children who were in situations where their parents had lost custody, given up custody or whatever, did not have custody simply because they were not able to provide the care that their children needed—in other words, there were no protection issues involved—we acted on that immediately. We actually compiled a list of 72 such cases. I'm happy to tell you that there are only 18 of those cases outstanding. The reason they're outstanding is because they required court interventions, and those court dates, I gather, are scheduled for the fall. So we've made really good progress on that. I think only one family actually said they would prefer that there be no change in the custody relationship for their child.

I think it's also fair to say—it's good news—that these parents feel they are getting more support from the system, to the extent that they can feel better about retaining custody or reinstating custody for their child.

Ms. Horwath: That's the first recommendation of the Ombudsman's report, right? What about the other three recommendations in the Ombudsman's report?

Hon. Mrs. Chambers: Well, we continue to work on all of the recommendations from the Ombudsperson's report. They're all work in progress.

Ms. Horwath: Since the Ombudsman's report was tabled back in May, how much has been spent to accommodate children with special needs who were affected by the issues around custody and access support services that you were just talking about?

Hon. Mrs. Chambers: The 72 cases? The services being provided to those children and youth have been continued. The services they were getting before have not been disrupted.

Ms. Horwath: So in other words, there was no need to actually invest more dollars. It was just giving custody back to the parents, is what you're saying.

Hon. Mrs. Chambers: Giving custody back to their parents is what the emphasis was.

Ms. Horwath: OK. But what the families are saying is that they're still feeling that there has not been an appropriate response to the issues they raised. What you still have is people dealing with the fact that their children are in short-term facilities. In some cases, they have to, every couple of months, reaffirm that they can have another short-term placement before a permanent placement is found for them. They're still, in many cases, in situations where their children are in far-flung areas of the province compared to where their family home is. This is consistent. Not only Cynthia Cameron—I've already raised that issue today, and she's here to put a face to this issue—but there are also many others I've heard from. The McLaren family, who have their son Jordan right now in a care situation, feel they're still getting a bureaucratic run-around from the officials they're dealing with, because they've gone through several phases. I know in your remarks you talked about how your regional representatives were coordinating with each other and making sure that everything was being done in a coordinated and consistent fashion. Unfortunately, the consistency appears to be that it's consistently not solving the problem for the families in terms of getting a permanent placement so that they can move with their lives. What we have now instead is families who are still uncertain of what the future holds for their children. They are unable to make plans for themselves and the rest of their children; they are unable to move their families along; they are unable to make decisions around vacation and all kinds of other things.

I'm just not sure, Minister, if you're telling me that you're pleased with this pace of reform or if you have

any other further responses for these families who are still living in a day-to-day situation in terms of a crisis of care for their children.

Hon. Mrs. Chambers: I think it's very important that everyone understands that the whole matter of custody does not necessarily involve a physical relocation of a child or a young person. I think it' s really important that everyone understands that we have said there will be no reduction in the level of care provided to these children and youth. If there are cases where parents are experiencing otherwise, then I would definitely encourage them to continue to work with the regional offices and the regional services providers, and I am sure the deputy is taking notes as to what she should be following up on here.

My intention is to ensure that parents and their children and youth are dealt with fairly and provided the support they need. As you know, I cannot address individual cases, and neither am I going to suggest that we should take individual cases out and give them priority over other individual cases. That would not be appropriate. I don't think that's what those families would want either.

I want to reaffirm to the families you speak about and the families who are represented here today that they do have my commitment. When we acted quickly—I want to thank my ministry officials for picking up on that direction and moving with it quickly. Prior to that, they were only adhering to the direction that they had previously been given. This is new direction from our government to my ministry officials, and I appreciate what they are doing there.

Is the problem totally fixed? Obviously, if there are any parents who are dissatisfied and feel that they are getting any less attention than they had received previous to giving them the opportunity to resume custody of their child, then we will want to hear about those.

Ms. Horwath: Mr. Chairman, how much time do I have left?

The Chair: About eight minutes.

Ms. Horwath: Thanks, Mr. Chairman.

Minister, again, we bring particular cases forward to highlight systemic problems. I think you would acknowledge that that's the obligation of members of this Legislature, that as these issues come forward, we need to make sure that the systemic problems that cause particular families to have an issue get addressed. In that vein, there's something that I'm hearing echoed in a number of letters I've received in regard to the ongoing problems. The bottom line is, people are saying that the ministry is simply not addressing the concerns that are being raised. I think what that means is not just the first recommendation in the Ombudsman's report but all of the other recommendations that continue to not be addressed.

I don't think you answered the question in regard to when, specifically, we expect the other three recommendations to be addressed. When will you be in a position to be able to say that the Between a Rock and a Hard Place recommendations have been completely addressed? The runaround is still occurring for families. If you don't want me to mention names of families, I won't. But families write to me and say, "This process is nothing short of crazy-making. It feels like they're trying to challenge us to see how long it's going to take before our children fall by the wayside and are no longer eligible for funding until the adult system kicks in." Of course, there are other questions around how that transition occurs.

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Others are saying that they are being told they can't even address what's happening when their children are reaching the age of 16 and trying to figure out where their care is going to come from after that age because care providers are saying, "We're not prepared to take that on unless we're guaranteed by the ministry for long-term funding to meet the needs of those young people as they reach that age."

Minister, I really would like to know specifically whether you have directed your staff to come back with an implementation plan with timelines and accountability attached that implements the other recommendations of the Ombudsman's report and specifically deals with the fact that special-needs agreements are still not being directly entered into with families and that there are still families who are not seeing permanent solutions to the residential care for their children's situations.

Finally, when will you know for sure that the ministry has a handle on this entire file, so that I don't get questions coming from community members who indicate that from their perspective the ministry—and again, not as a result of their individual case but the ministry overall—is in a crisis of disorganization and unable to address their concerns?

Hon. Mrs. Chambers: Let me address the matter of special-needs agreements because we have also had this discussion with the Ombudsman. You will have noticed in the Ombudsman's report that while he had an interest in special-needs agreements, he also recognized that special-needs agreements did not guarantee the level of service that children and youth and their families might require. He actually used the term "ad hoc" in reference to, if you like, the value of special-needs agreements, because special-needs agreements, which have existed for quite some time and were instituted for quite different reasons, don't actually guarantee services.

What the Ombudsman seems to agree with us on is the need to strengthen the services we provide so that all children and youth and families who need these services can get them, not just people who have managed to negotiate some special service agreement. There are relatively few of those in place. As a matter of fact, I have actually looked through the format of the special-needs agreement and the special-needs agreement actually contemplates the removal of custody, which is exactly what the Ombudsman has said he doesn't agree with and, incidentally, we don't agree with. If there are no protection concerns, then this is actually not an issue for the children's aid societies.

Ms. Horwath: Can I ask then, when is the result going to occur, though? If the special-needs agreement as it's documented now is not the appropriate way to address the problem, when is the other alternative going to be proposed? What's the timeline for your proposal for the alternative to the special-needs agreement, and when are the providers of service going to feel that they are getting the supports they need from the ministry to provide the services necessary?

One of the other things that has come to light from the work that I've been doing with some of the families is that prospective service providers feel that they're floundering within this process, that they don't know what to do and how to bridge the messaging they're getting from the ministry staff to the families who are so desperate to have their children placed.

Hon. Mrs. Chambers: Well, let me give you an example of what we've done already. At the end of June, my predecessor announced an additional $10 million to address some of the priorities identified through the planning process and the planning tables on children and youth with complex and multiple needs. This was as a result of work that had been underway for months prior to that to identify better and more innovative approaches for services and support to meet the needs of this population. So we have in fact made great strides in increasing our support in that area and our focus on that area and core elements of the plan—

Ms. Horwath: Can you outline the exact areas the $10 million is being directed to?

Hon. Mrs. Chambers: The funding has been allocated to the regional offices and the regional offices have been given the flexibility to address immediate pressures while supporting local capacity and enhancing community supports. So core elements of the plans to utilize the $10 million include flexible specialized respite, a range of in-home and community supports, residential beds, interdisciplinary assessments, care coordinators and the availability of flexible funding that allows them to respond to the needs of specific families.

The Chair: Thank you, Minister. Perhaps it might be helpful if you were to furnish a copy of the memo to the regional office outlining that flexible format for us. That would be appreciated.

At this point in the proceedings, according to the standing rules, you have up to 30 minutes to respond to any statements or comments that have occurred prior. I'll leave that to your judgment, and when you feel you've completed that, we will begin our regular rotation.

Hon. Mrs. Chambers: All right. Thank you.

Mr. O'Toole, there is no question that we are reviewing how children's aid societies operate now. In my new capacity, as you would well know, I don't have the ability to meet with individual families in my constituency office any more, but I certainly had almost two years of that kind of experience and I know of what you speak. We also recognize that we are dealing with very, very sensitive situations when we deal with child protection issues and children's aid society-type issues.

I want to say that in all that I have seen, there are best practices and better practices, and in some cases, for example amongst the 53 children's aid societies, there are also opportunities for some of the societies to benefit from the strengths of other of the societies. I would have to say that the concept of children's aid societies seems to be a workable concept. Is there any room for sharing best practices amongst them? Yes. There is also room for increased accountability. We are, as I said in my opening remarks, helping them to move their approach to dealing with some kinds of situations in the area of custody issues, for example. Bill 210, which my predecessor announced, is intended to increase the emphasis on family supports and kin supports. I have received letters from grandparents that actually are difficult to swallow, where they feel that had they had the ability to be involved in their grandchildren's cases, if you like, they could have intervened with a family or kinship-type solution. We want to see more of that.

If you don't mind, I might come in my response to reflect some of what Mrs. Munro said as well in terms of what kind of evidence we have seen out there that would cause us to want to deal with this better. I think you would probably agree with me that a child moving every 22 months from one foster home to another kind of arrangement is not exactly our definition of permanence or stability. Some of these children have other challenges which would therefore just be magnified by a less than perfectly stable home environment. I'm not saying any of us have perfectly stable home environments, but to offer these young people greater hope for stability and support in their homes is what we're after. When we have 18,000 or 19,000 kids in the care of children's aid societies and we're seeing just over 800 or so adoptions per year, I think we can do a little bit better than that. We are working with the societies. We also recognize that there are financial challenges, and we believe, from the reaction we're getting from them, that they are entirely on side with wanting to look at how they operate, because their focus is also on providing the very best care and opportunities for the children and youth in their care.

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On the matter of autism and the auditor's report, I want to emphasize that we are focusing on a continuum of services. We are looking at ensuring that children get the support they need, and that's what I meant when I said that I have directed our regional service providers to assess the needs consistently. There are challenges associated with this. I think it was Mr. O'Toole who said that if there were opportunities for perfection, they would have already been found. But we will certainly not give up on working toward improving how we care for these children, youth and their families.

When I spoke about increasing capacity in the system and the college-level programs, and Mrs. Munro asked for a little bit more information, I interpreted that as the quality aspect of it, the expertise re college programs. This is in fact a new program. This followed, actually, an initiative where we were able to get existing college pro-

grams to increase their capacity to take in more students, again, to enable us to provide greater capacity in the system. This program of which I speak involves, I think, nine colleges. It's a new program. This is the first cohort of students. It's two semesters, 12 courses. There are full-time, part-time and on-line options for taking these course. It's intended to support the instructor therapist level.

We have, I think, three levels of therapists that we use in autism spectrum disorder treatment programs. I am looking for the guidelines document which in fact speaks to—and I have it here; it's just a matter of finding it. Here we are. You found it because I found it. Isn't that how it always works? We have three categories of staff, and we actually do stipulate the qualifications required. We are really keen on ensuring that we have the calibre of staff. The clinical director is responsible for overseeing, monitoring and evaluating the intensive behavioural intervention. The qualifications for the clinical director are: training and extensive clinical experience in intensive behavioural intervention for young children with autism; the clinical director would have a doctoral degree in psychology, and be registered or eligible for registration with the College of Psychologists of Ontario.

Then there are senior therapists, Mrs. Munro, who are responsible for a set number of children and for supervising the instructor therapist. The qualifications for the senior therapists would be: have, or be working toward, a master's level graduate degree in psychology or a related field; six months to a year of direct clinical experience in an IBI program for children with autism; alternative combinations of extensive clinical experience in intensive behavioural intervention with children with autism, and other educational backgrounds might also be appropriate for the senior therapist.

Then we get to the instructor therapist, which is where we currently have 100 new students enrolled, and within a couple of years we'll have up to 200 in that new program. The instructor therapist is responsible for providing intensive one-on-one and small group instruction. To support this work, the therapist will be responsible for maintaining a daily data book for each child that will help in monitoring the child's progress. The senior instructors supervise the instructor therapists. The qualifications: instructor therapists should be community college or university undergraduates in a related field; previous experience providing intensive behavioural intervention would be of benefit. I should mention that that new college program also includes two on-the-job placement opportunities.

In terms of the angst amongst parents, I have to acknowledge that the waiting lists have grown recently because we are not turning kids way. But we are, at the same time, working on building capacity—hence my excitement about the new program, which will significantly enhance capacity.

How do we reduce demand for child protection cases, you asked? Well, some of that goes back to giving kids a better start in life, providing parents with stronger supports and also identifying the issues that could, perhaps, be supported at an earlier stage in life. When you asked about what kinds of things could be identified earlier, one of the results that I think will please you is related to the results of hearing tests. In 2004-05, the average age of children who had been diagnosed with permanent hearing impairments was reduced from two and a half years to four months. As I've heard said by parents who have children with special needs, a year is a lifetime, so two years makes a huge difference in the life of that child. I just wanted to provide those examples.

On the question of private operators in child care, and I think Ms. Horwath didn't raise that because she figured I would respond to your question: 95% of licensed child care spaces are now in the not-for-profit sector. We expect that this trend will continue as the expansion takes place over the next three years. We're certainly encouraging municipalities to establish these new spaces, any expansion projects, in close proximity to schools. The primary focus of this expansion is four- and five-year-olds, and so they would be in junior and senior kindergarten now. The ideal situation would be that there would be no need for them to be transported away from their schools or between their child care location and their school location.

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We feel that there is absolutely no place for big-box commercial child care in Ontario. Having said that, there are a few communities that only have private child care providers, and we are happy that those exist, as I'm sure others would be happy that they exist. In terms of how funding is being allocated, whereas we are not funding the expansion of spaces in for-profit operations, we are in fact funding the operational side. That included enhancing compensation for child care workers. The emphasis is not just on a place where you can leave your kids; it's on early childhood development. And, no, we are not suggesting that child care workers or early childhood educators know how to look after kids better than their parents do. What we are recognizing is that something in the order of 70% of working parents with kids under the age of five have said they need child care. So what we're trying to do is ensure that we are helping those parents to balance their family and work obligations.

The establishment of the college of early childhood educators is an attempt—and, I think, the right thing to do—to raise the bar in terms of quality and to ensure that our kids have the very best opportunities when they're in the care of others.

I'm sort of jumping around here, so whatever I don't cover, please ask me in follow-up questions today or tomorrow.

On child protection, Bill 210 was mentioned. We are, as I think I've alluded to already, trying to make sure that there are more flexible arrangements, that there are greater opportunities to involve kin and familiar surroundings for kids. We are moving toward kids not having to go into temporary group home settings before they are provided with more stable environments.

On the subject of consultants in the schools—Mr. O'Toole raised that issue. There are a couple of points that you have made that I will pass on to my colleague the Minister of Education. One particular one that I know he is giving consideration to is the idea of consultants in the classrooms.

When you say that consultants are not permitted to be in the classrooms, it's actually the private consultants who are not permitted, under current contracts, as far as I am aware. So, for example, the 160-some consultants, which will increase to 190 by next spring, are in fact able to provide support to the teachers. I have heard concerns about families not being able to bring their own consultants into classrooms to provide that support, and I am of the understanding that that is related to agreements with unions.

Should I go on?

The Chair: Minister, if you have completed your responses, we can get into a regular question rotation, but you still have a few minutes left.

Hon. Mrs. Chambers: I still have a few minutes? OK.

Need-to-know details of child care announcements: How will this be done? This was Mrs. Munro's question. The municipalities and their service managers have actually been working really closely with my ministry. We have given them a very aggressive timeline on this. In fact, some of them are saying they'd love to have more time, and I'm saying, "Well, kids would like to have spaces in child care." So we have asked them to bring their plans back to us for approval by the end of October of this year. Some are already on their way. Remember that there are wait lists for licensed child care spaces. We are really eager to assist them in whatever way we can, and certainly in the way of turning around and approving the submissions they bring to us over the next few weeks.

On the question of child care subsidies, we are working toward an income-based subsidy that will provide subsidies for a larger number of families. That work is nearing completion. I'm looking forward to being able to pilot that in a couple of regions so we can make sure it works really well. In fact, it wouldn't be a pilot; it would be a parallel operation, so that while we are testing it, the supports that parents are getting now would continue.

Mr. O'Toole would like to ask me a question, I think.

Mr. O'Toole: No. I'll volunteer for a pilot.

Hon. Mrs. Chambers: You want to volunteer for a pilot? I shouldn't call it a pilot; I should call it a parallel operation, because we have to ensure that we have data against which to compare it. I know we have data for Toronto and for York. I don't think we have data for Durham, but I might be wrong. I'll look into that.

Identifying conditions earlier: Mrs. Munro asked if I thought maybe the checkups by 18 months could possibly identify autism spectrum disorder. From the materials I have read, that is quite possible, because from what I understand, it's typically around age two that diagnoses are being done. I would suggest that because there will be this focus on following up from birth, in fact even before birth, we will be able to provide parents with the kinds of tools, the signs. I've visited a number of centres, including children's treatment centres, and they have some "Look out for these kinds of signs" types of pamphlets that suggest it's possible that parents can help in early diagnosis of some of these cases. That's the kind of resource we want to be able to provide to parents and their families.

The matter of my visits to children's treatment centres and other places just reminds me of Ms. Horwath's question about children not necessarily being located close to their families.

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I have visited the Child and Parent Resource Institute in London, in southwestern Ontario, and met some of those amazing kids and their incredibly caring staff at that centre and learned a bit about where some of these children come from. Some of them come from significant distances away and live at the centre. Obviously, I didn't speak with all of them, but I really got the impression that the children's parents, in most cases, are more concerned about the wonderful care their children get there than the fact that it's not all that convenient for them to be visiting them because of the distances they have to travel to get there.

But there is wonderful work going on there. The parents have custody of those kids, even though they are not physically located in their own homes. In terms of public perception, there may also be some confusion as to what "custody" means. These parents do have custody of their kids, even if they are in a residential setting outside of their homes.

The model communities and the different demographics: Yes, for the Best Start programs, those communities were selected to ensure that we had a good take. For example, Timiskaming and Lambton will not only provide us with, in the case of Timiskaming, the francophone population but will also provide us with some insights into rural challenges, or challenges outside of urban areas like Hamilton, where parents have to travel distances to secure services or support. We are expecting wonderful results out of these pallets.

I can also vouch for staff whom I have met, who are so excited. There's one fellow in our southwest regional office who is responsible for the Lambton model, and he says he has been waiting all of his life to do this. He's so excited about it. He know it's going to be so good for that community.

Do you want me to go on? How much time do I have left? We need a clock.

The Chair: You have another four minutes, if you choose.

Hon. Mrs. Chambers: You would like to get—

Mr. O'Toole: No, no, we can just dialogue.

Hon. Mrs. Chambers: OK. All right. I was not ignoring Ms. Horwath's other issues. I look forward to your specific questions. I think I may have touched on some of the issues that you raised.

On the subject of children's mental health, that's one that's really very troubling to me. As Mr. O'Toole men-

tioned, the occurrences in terms of diagnoses are troubling. We are hearing one in five children and youth under the age of 18 being diagnosed with some mental health condition or other; some less severe, some very severe. Those numbers are in fact quite troubling. Don't you think that's high? It's higher than I would have thought. If we look around this room, it suggests that we probably have some people in here who need help, with that kind of ratio. It's very troubling, and it is going to place huge demands on the system to provide supports for our kids.

We have, as I mentioned earlier, invested $25 million of new money in children's mental health services, growing to $38 million this year. Approximately half of that money has gone to ensuring that we find ourselves capable of recruiting and retaining, because the majority of people who work in these fields don't make huge salaries; and the other half have been used to introduce more than 100 new programs and expand on about 90 other existing programs. I had a delegation from Halton who told me on the subject of children's mental health that what they're hearing from their constituents as their biggest challenge is navigating the system. There are so many service providers out there. There are so many opportunities for us to help parents navigate the system more effectively because there are so many services out there. We will work on that.

The Chair: Thank you very much, Minister. We will now begin 20-minute rotations, if everyone is agreeable. I will recognize Mr. O'Toole.

Mr. O'Toole: Thank you again, Minister. It's a very relaxed style of dialoguing and communicating. I've got maybe five issues. I'll sort of just put them out there. We'll have enough time over the remaining few hours to listen to one another and to you so that we're talking about central issues.

The first one I want to bring up is really two cases. I won't mention names, but they do tie to the themes that are developing here. One is with respect to autism. This is a case where I could get into detail if required; I'm not. But I'm going to put it on the record just to convince my constituent—a few of them, actually, who are involved in the autism issue. One parent has just actually sent me a thing; I'm reading it right off my e-mail here. This parent has a son in grade 4 and, after the school's organization at the opening of school a couple of weeks ago, she has just removed him to home schooling because there was no EA in the classroom. I don't blame that on you, but the response they got from the ministry was that there are 160 autism spectrum disorder consultants to help teachers and educators understand. They're not an EA, kind of thing; they're some other new title, probably in some contract, a job description, blah, blah, blah. Do you understand? This implementation transition will be something we need to keep an eye on.

I don't say that critically. Having quite a bit of time and having had five children, a couple of them involved in education, I'm concerned that we get it right. Forget the turf stuff. Children with special needs—even Mustard-McCain said early intervention and identification are absolutely critical in all of this. So I think, to be complimentary, you are doing the right thing. There needs to be some flexibility out of the current model. There's a pretty rigorous model to flow some funding there. Who flows it from what ministry—the children's treatment centre is a perfect example. You get almost little silos operating in the same building because they're funded from different ministries. Not to criticize the few children's treatment centres—Grandview is highly regarded in my area, so I would not in any way criticize that.

I do know that the service providers—I have met with Kinark and others, and this whole idea of who's kind of organizing this maze, as you described it, to access services, assessments, how many assessments do we need to have done, aren't they expensive, who's paying? It's a lot of red tape in this whole diagnostic and legitimizing the diagnosis as being at some state, whether it's some level of—they use code language, so I won't try to go there. I don't say it critically. We could get stuck throwing a ton of money at it without fully engaging in the problem. There's a whole level of severity I'm not qualified to talk of, but when you throw numbers out, like you've got these 160 people out there—actually, what are they doing? You've got the Ph.Ds. and you've got the structure, and if you look in your budget you've got lots of money tucked in there. It all breaks down as wages and benefits, technically, and I would hope that we're not building another level.

What are the expected outcomes, ultimately, Minister? In best practices you usually say, "Here's the investment. Here are the expected results. Here's how we measure them objectively, independently"—whatever. That's kind of why I'm interested in it. I support it. It's real, so you can observe it and go on from there.

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The other case: under the autism file I have—and I will be very careful not to mention anyone's name because I have been criticized in the past; I'd like to respect my constituents—but in this case let's say very competent parents. Let's say that, with some qualifications that would be appropriate, they have kind of an individualized funding agreement. I don't know how that works. In their early intervention they've identified—they're trained. They're professionals, maybe even in this area. They've got the therapist who comes in and then is off for a couple of days, and then they get another therapist, who knows nothing about the child. In other words, they want the money; they'll run the program.

I know these are anomalies that will come up, but this is what I think is individualized funding, self-directed almost. If they've been identified and, "This is how much you get for this particular case," and they're qualified and competent by some measure or mechanism of figuring this out—I can bring this case up because it has been talked about in the House before specifically, and I was roundly criticized for using their name. But the reason I say it is, "Train the trainer" is what I think. It's great to have a degree in some particular speciality. Mine hap-

pens to be a general kind of degree. I know a lot of things about nothing or nothing about a lot of things. Which is it?

I guess the point is, that's the point. If the individual parent, for life, is committed to that child, and we're going to invest considerable amounts of money, and through some mechanism we know that the family, if it has the supports, will survive, and without the supports it could cost all of them the roof over their heads, I would say we need to consider a parallel model in a pilot setting where parents are allowed to be trained themselves, because they're going to have it forever. Through some socialization process, they're going to have to live with it, so they may as well be part of it, and not somebody with a Ph.D. qualifying them to do a lot of nothing, because they won't be doing it. They'll be carrying a briefcase and going to conferences and making about 200 a year. That's the way it works.

So the real people are going to be just other people like me—hopefully not that bad. Hopefully, they'll be people with reasonable incomes and committed to that 8-to-4 thing; not too many weekends or evenings or the union will be upset about it. Train the trainer. Get some of that parallel system so we can evaluate the expected outcomes. Those outcomes could be done by the qualified master's degree with a statistical degree saying, "You've got the three boxes, so you're getting 75." Do you understand? You can evaluate the outcomes, which is important.

Allow the parents to be educated. Here's the choice: individualized funding. Get your own psychologist who can give you some guidance about models and little modules by which you can deliver these things. I won't go into it too much, but this idea that one size fits all doesn't work. It doesn't work in education. Twenty kids in the class is fine if all the kids are from a certain kind of socio-economic background and academic abilities. If you've got a bunch of little rascals there, maybe nine are too many.

The second specific case—and I may write to you and ask you to look into it—is the case of a child where under court order there were visitation rights granted. This 12-year-old child was at Falconhurst. There have been letters on this and other kinds of correspondence through the CAS in Durham. Both sides have lawyers now and are spending a fortune. This is a court-ordered visitation issue. I don't get it. My impression, from the one phone call I've had directly with the director of children's aid on this, is that the suggestion was that the case worker had kind of dug their heels in: "That's what we're doing. You're powerless here." When you're dealing with that kind of bureaucracy, you are powerless. They've got all my money to spend, as well as your money. Do you understand?

Then I go in here, and I want to look at the estimates themselves. I'm actually looking here specifically, so this is kind of a notice. If I look at page 27 of the estimates, it just shows me, under legal services—you're responsible, so I suppose you can tell me—that we're spending that whole amount, $2 million. I would think most of that's providing badly needed protection for the ministry under these circumstances. But if you look through here, one of the things that I see as being cut significantly throughout almost all of the sub-tier sections of the budget, as it's structured, is transportation and communication. It's been completely whacked in almost each of the little files. If you look on page 41, and you're looking at "Children and Youth Service Program Operational," it's being cut by 28.2%. I don't know if those are transfers to other areas.

So I put that whole legal thing as part of what I think the CASs are into. If you wanted to provide the committee—and I could put this as a formal question: When we call it "program service money" through the CAS or other service providers, of the total $3-point-something billion, and how it's put in there as operational money or service money, how much are we spending on legal services? You've told me there were 21 cases. You've got them solved. These are orders that the Ombudsman has been engaged in and the auditor has commented on. How much are we spending on legal services or some other mediation arbitration process that we need to go through? Do you need a minute?

Hon. Mrs. Chambers: On that, I would be happy to get back to you with an answer to that question.

Mr. O'Toole: That would be for all members of the committee. Just give us a flavour of it. We're here to say "Let's make best use of providing services," not consult and surround with various litigation mechanisms.

Hon. Mrs. Chambers: I understand. So can I commit to bringing that back to you tomorrow?

Mr. O'Toole: Sure. No problem. No big hurry. I'll just put it in the big file.

You said there were 19,000—

Hon. Mrs. Chambers: Are you also going to give me the opportunity to address some of the other items you have raised? Because there have been a few.

Mr. O'Toole: Yeah. There's just been two that I've started.

Hon. Mrs. Chambers: Should I go ahead now?

Mr. O'Toole: Sure.

Hon. Mrs. Chambers: I would like to speak with you about the idea of giving parents funding and training. Certainly, training for parents—to help them understand what to expect in terms of their child's behaviour and how to work, like you say, not at the Ph.D. level, but certainly at the quality-of-life improvement level—is something that a number of our agencies are doing. I actually met with one service provider who has been placing very significant emphasis on just that. I was really happy to hear that, because I think that's very important.

Can we do more? I think we can also tell parents about some of the courses that are available. One parent wrote to me asking about formal courses that are available. They made reference to a course that's available in some of our community colleges. I think it's a two-week course, or a relatively short-term course. As you say, it's not going to make them therapists, but it would certainly go a long way to helping them to understand how to work with certain types of situations.

Mr. O'Toole: Many of these parents, as you probably know, are super-engaged.

Hon. Mrs. Chambers: Certainly. Absolutely.

Mr. O'Toole: They have gone from watching television and having a coffee to absolute activists.

Hon. Mrs. Chambers: Yes. I understand.

Mr. O'Toole: Good data is to harness that.

Hon. Mrs. Chambers: Yes. I agree with you.

I'd like to just tell you about what we call direct funding agreements. Approximately 30% of our funding is through what we call direct funding agreements, where parents will choose to establish their own service program and secure services from private providers. It's very important for me to explain to you how that works.

Mr. O'Toole: I have a reasonable idea. This one particular case is involved in that.

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Hon. Mrs. Chambers: Well, let me tell you, because I didn't understand how it worked. I dug and dug and dug until I think I now have a good understanding, and I've reviewed the guidelines as to how that works. I think it's really important for parents to know that this is not an end-run of other service approaches. You did mention that we need more than one model. This is in fact another model. There is one model whereby the regional service provider works with the ministry's regional office etc. in defining and designing programs for families based on the assessment that is done. There are nine of these regional service providers associated with our nine regional offices. They are very successful and effective service providers.

Once they get to the top of the wait list for service, parents are able to choose whether they would like the direct funding option or have the services provided to them through the regional program. Here's how the direct funding approach works: If a family chooses to receive funding to purchase IBI services from a private provider, the regional program will determine eligibility for intensive behavioural intervention services; determine the service/intensity/setting/duration of IBI required; give the family information about the funding available, including the hourly rate for services and supervision; and refer the family to the Autism Society of Ontario for information about private service providers. The family, of course, is responsible for selecting and contracting the private provider, not the program. However, the regional program will approve the service provider, so this is not going to undermine the quality of the care that family receives. The regional program will also develop a funding agreement with the parents that, at a minimum, identifies the level of funding provided by the regional program, the approved level of IBI service, the supervisor for the instructor therapist providing the service, the level of supervision required or expected, and any other information required from the parents and/or the IBI service provider that will aid the regional program in monitoring IBI services. The regional program will also administer the funding according to the funding agreement and reconcile any unspent funds, reassess the child's progress and continuing service needs at least every six months in collaboration with the supervising psychologist of the private program and the child's file, and will provide transition supports if requested to do so by the family. These programs are in fact in place and are used in about 30% of the cases.

You mentioned transportation costs. I can't remember which particular file you were looking at, but certainly one of the areas where we have not spent as much on transportation as we had budgeted for is the youth justice area, where we did not have a really good sense of what we would have to pay out, and contracts that we have been able to establish with the Ontario Provincial Police to move the young people in the system between locations have worked out far more favourably than had been anticipated. That's another example of some of the experience that we have had as we have been taking files away from other ministries that were more integrated. For example, youth justice files were more integrated in the community safety and correctional services type of scenario.

The Acting Chair (Mr. John Milloy): Minister, just to let you know, you have about one minute.

Mr. O'Toole: I just want to get a couple of extra items on the record here. That would be helpful. I would encourage you to review those line items under "Legal Services," for youth services.

Hon. Mrs. Chambers: We will do that.

Mr. O'Toole: Every one of the Best Start program—they all have cuts to transportation and communication. Maybe you're getting Internet up and running, and real-time conferencing.

Hon. Mrs. Chambers: I think that's a good thing, because it means our dollars are going to care.

Mr. O'Toole: Exactly.

A couple of things. The reduction in Early Years centres—that's actually a very good program, and it also ties into your strategy on child care.

The Acting Chair: Mr. O'Toole, you have about two seconds.

Mr. O'Toole: Is it two seconds? OK. I'll ask for unanimous consent for more time.

The reduction there is about $18 million. It's operational money for Early Years centres. That ties into hard-to-service areas like Port Perry. It's a rural area. It works effectively. It would be difficult for any of the schools to integrate. In all cases, large urban, your footprint works for attachment to schools or whatever. Rural, it's difficult.

The Acting Chair: Mr. O'Toole.

Mr. O'Toole: I appreciate that, Chair.

The Acting Speaker: Ms. Horwath.

Ms. Horwath: I have maybe three or four specific questions back to some of the special-needs issues, and they are ones that I think are fairly clear.

The first one is around the additional funding for the in-home and care supports that is coming out of that $10 million. I met recently with a family in Hamilton, the Bassets, who are very concerned about their ability to

cope with their special-needs child. The child is just a baby; she's only 13 months old. Her name is Treva. She has a number of complex care problems. Some of them are specifically medical problems, and so there is a double problem in that the amount of medical supplies that they're able to access is being reduced, which is putting more of a burden on them physically in terms of their ability to cope with the needs of their child. There are a number of things that they receive, but they also receive special services at home in terms of respite care and those kinds of things.

I guess my question around that is fairly specific but twofold, and that is, will any of the dollars being flowed to address children with special needs in any way pick up some of the piece that's not being dealt with by Ministry of Health dollars? If not, will you advocate for that? Secondly, apparently there have been significant cutbacks in or underfunding of respite care or special services at home for families. Will that $10 million address some of that problem?

Hon. Mrs. Chambers: I'd like to have one of my senior ministry officials speak to the $59-million announcement made by the Minister of Community and Social Services.

While they're coming forward, I would like to let you know that we have also named a number of interministerial committees to look at ensuring that there are transition programs and plans in place as our children and youth get older and move out of this portfolio and into, for example, community and social services, or where there are joint interventions between the Ministry of Health and ourselves or the Ministry of Education and ourselves, or others. So there is definitely work being done there. It is not finished work, Ms. Horwath; it's work underway. But we recognize the need to do that.

Ms. Horwath: OK.

Ms. Wright: I'm going to ask Assistant Deputy Minister Terry McCarthy to come up and speak in more detail to your question, Ms. Horwath. This is my second week on the job, so you'll have to excuse me if I'm a little behind.

Ms. Horwath: No problem.

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Mr. Terry McCarthy: Thanks very much for the opportunity to provide a response.

The Ministry of Community and Social Services very recently announced a major initiative, an increase of $59 million to support developmental services needs in the community. Of that $59 million, specifically $8.5 million was directed at special services at home.

Ms. Horwath, we fully expect that that $8.5 million will go a significant way to resolving some of the difficulties and waiting lists we've had in special services at home across the province. In fact, we'd expect that the majority of that money would be directed at children.

Ms. Horwath: Great. Waiting lists are a problem, but I guess apportioning of care is a problem too. For example, when the pot was depleted, parents were told, "We have enough to pay for 25% of what you're eligible for in terms of assistance." What you're saying is that this $8.5 million from the $59 million from MCSS is going to be able to fill that gap, not only from what has been depleted from parents who have some service now, but also whoever's on the waiting list. Is that right?

Mr. McCarthy: It's partly true. I don't think there's been any depletion in the program. Quite frankly, the special services at home program has been increased. I believe, in nine out of the last 10 years, SSAH had significant increases year over year.

This, as you know, is one of the most popular programs that we, as a government, offer. It is an individualized funding respite care program that offers significant flexibility to families. There is a great demand for this program partly because of its flexibility, but there is a fixed pot, and year over year local ministry offices have to make decisions proportionately to need.

I don't believe any families in Hamilton as a group would have had their allocation reduced, quite frankly, unless there was a significant increase in the wait list.

Ms. Horwath: That might have been the case, because my understanding from this family is that they were actually told that although they're eligible for more service, there's no money left in the pot and so they're only getting about a quarter of what they would get if the pot were full.

Mr. McCarthy: The pot is full, to be fair. I think it's absolutely true when you say that when we assess the needs of folks against what we have available in special services at home, there is almost invariably a gap if we expect special services at home to fill that full gap; in fact, we don't. We expect a number of other programs to come to the aid of parents. One of them is ACSD, which is, as you know, income-tested. Parents are eligible for up to $400 a month based on income to help them meet the needs of their special-needs child. This is an increase of up to $25 a month from six or so months ago.

As well, we have many community-based respite programs which are almost always available to families in the community. SSAH currently is a program of last resort. So we expect families to be served as much as possible by community-based programs and then SSAH is seen as a top-up to the best extent that it can be.

Ms. Horwath: I appreciate that, Terry. Thanks very much. Unfortunately this is one of those extremely severe cases where this baby needs 24-hour care and the medical side is not—again, there has been cutbacks there in CCAC. That's a whole other issue.

I just wanted to be sure that that $8.5 million is going to special services at home. I think you've indicated that in fact it is, and that should relieve some of the pressure, which is good news. So I appreciate that.

Can I just ask another question? That's around the autism piece. Again, as always happens, you'll get the specific cases from your own community, but I was approached by a Mr. Disipio, who was wondering what—you talked about the future in terms of the work that you're doing to train people to provide services when children become of school age, and that's good news. But

what they're experiencing now is concern over the fact that although every two or three months their cases are reviewed and no flags go up, as the children are approaching the age of six, all of a sudden, notwithstanding no mention of anything during their progress reports, they're told that the IBI treatment is not benefiting the children any more. Technically, they're not being told, "Your child is now almost six and will not be eligible for IBI." Instead they're being told, "Your child is no longer benefiting from the IBI treatment."

I guess I'm just not understanding what the message really is. It seems to me that the work you're doing is positive work around making sure that there are more resources available to families and children in terms of personnel who have training in IBI treatment. On the other hand, we're still sending the message to families that IBI treatment is not something their children are benefiting from.

So can you just clarify for me what's not matching here in terms of, on the one hand, saying, "IBI is important; we're getting more people trained in it so that kids can get that when they're in school," and yet as kids are reaching that age of going to school full-time, they're being told, "You're no longer in need of IBI because it doesn't do you any good"?

Hon. Mrs. Chambers: Thanks for the question. I need to clarify one thing to start with, and that is that the college program will actually provide therapists, not just for in-school support but certainly for therapy.

Ms. Horwath: OK.

Hon. Mrs. Chambers: The other thing I need to make very, very clear is that we are not aging out kids, if that's what you think people are hearing.

Ms. Horwath: I don't think they're hearing—

Hon. Mrs. Chambers: So if there is an assessment—

Ms. Horwath: Can I just clarify, Mr. Chair, because I don't think people are hearing that kids are aging out.

Hon. Mrs. Chambers: Or experiencing.

Ms. Horwath: Instead, parents are hearing a specifically different message, however de facto, that means "your child is aging out." So the language is not, "Your child is aging out," but the language is, "Your child no longer is benefiting from this treatment." It just so happens that that language is being applied to children who are in fact reaching that age.

Hon. Mrs. Chambers: I think it's really important for me to say to everyone here today that when we talk about assessments being done in a consistent manner, we mean assessment tools being used to determine exactly what kind of intervention a child needs at their particular stage in life. That stage could be anything—not necessarily age. The assessment tools that we have asked providers to use are not age-specific tools. They are tools that measure progress, for example, of kids who have been in treatment. I have spoken with regional service providers about their experience in using these assessment tools, and that's what they are. They're meant to be assessment tools that say, "This is the kind of progress being made or not being made," and, consistent with that assessment, "Here is the kind of care we would recommend."

We have not given service providers direction on what the results of the assessment should be. They do those assessments based on the tools that they're utilizing and their expertise. So we don't have anyone in our ministry determining what kind of care that particular assessment should drive. This is a model that is being developed with the service providers, and this is what I mean when I say that assessments are to be done in a consistent manner.

Ms. Horwath: So can I ask, then, Minister, just to finish that piece off: It is no longer the policy that children age out at six in terms of IBI treatment, so it is feasible that children will be able to continue to get IBI treatment after the age of six at this point in time?

Hon. Mrs. Chambers: I'm going to actually read from the directions that we have sent out.

Ms. Horwath: Do you know what, could I just get a copy of those directions?

Hon. Mrs. Chambers: Sure, absolutely.

Ms. Horwath: That might just speed things up, and that would be perfect. That way, I'll just have it.

Hon. Mrs. Chambers: It's now on our Web site—

Ms. Horwath: Excellent.

Hon. Mrs. Chambers: —and we would actually encourage and value the delivery of this kind of information broadly, because we have said, "Here are the guidelines that have existed prior to this," and we have said, basically, "Delete all references to age." That's the highest-level summation I can give you. In fact, it's entitled "Notice - Non-application of Age Limit for Program Eligibility."

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Ms. Horwath: OK. We'll leave it at that. I'm just concerned that there's a subtext there that families are experiencing something that says—even though the letter of the law, if you will, is that we're not aging out at six, I think what families are saying is that they're experiencing something similar, except they're calling it "lack of effectiveness of the treatment," or something of that nature. I have that on the record. It's important, and we'll follow up with that to see—perhaps there's a transition phase that's happening right now—what happens over the next little while on that issue.

The Chair: Ms. Horwath, would you like a copy of the ministry memo to the regional offices that reflects that?

Ms. Horwath: I've asked for that, Mr. Chairman.

The Chair: OK, and we will make note of that. If you can have that prior to the start of tomorrow morning's session, that would be appreciated. Thank you.

Ms. Horwath: Do I have a little bit more time?

The Chair: You have another five minutes.

Ms. Horwath: Good.

The next one that I want to raise with you is very quick, and that is the issue of screening. I attended recently a fetal alcohol spectrum disorder public meeting in Hamilton and found that in fact the screening for fetal alcohol spectrum disorder is something that can be done

with young children, and the earlier that this disorder is caught, the likelihood of better outcomes for children is significant. I know that we all supported Mr. Parsons's bill in terms of making sure that posters and notifications are up in places where alcohol is being sold, but that's only one small, small piece of a range of things that needs to be done to make sure that this absolutely 100% preventable disorder is addressed in the province. Is fetal alcohol spectrum disorder part of your screening process, and if not, can you add that or see if there's a way that we can begin to look at how that might be done?

Hon. Mrs. Chambers: I'm pretty sure I have seen it—is it on the Best Start list? Where is Lynne?

The Chair: Please identify yourself for the record, and then respond, please.

Ms. Lynne Livingstone: I'm Lynne Livingstone, with the Ministry of Children and Youth Services. We have a number of programs that do early screening with families, like Healthy Babies, Healthy Children. One of the screens there deals with a prenatal screen, and it does look at issues of alcohol and smoking and a couple of other things. It's a very quick screen and it's meant to highlight where there might be families that are experiencing issues. That's the first screen that's part of Healthy Babies, Healthy Children.

The second screen that's available is called the Parkyn screen. This is done in hospital postpartum. That's another opportunity to identify issues for families. It's not limited to fetal alcohol. It looks at a variety of issues that can impact on a child's development.

The other piece I'd like to highlight, though, is in the Best Start plan. We're looking to have, as part of the long-term vision, an 18-month well-baby visit that's standardized across the province. The reason we're doing this is that that is another early opportunity to be able to identify families that might have issues and concerns. It's another opportunity for parents and primary care providers to sit down and talk about that child. We have an expert panel that's working right now to give us advice on what that visit should look like and what kinds of things should be discussed. I know they are looking at what kind of standardized tool to use in that visit would help to identify a number of issues for families.

Ms. Horwath: Can I just follow up, then, Mr. Chairman, by asking, in terms of the postpartum screening that was mentioned, is that universal? Is that done with every—

Ms. Livingstone: It is offered to every new mother in the hospital. They have to consent to participate with the screen.

Ms. Horwath: So it's not universal; it's a matter of—

Hon. Mrs. Chambers: It is available universally. Whether or not they accept it is their—

Ms. Horwath: But it's not automatic.

Hon. Mrs. Chambers: It is offered automatically; it is not mandatory. So they can say, "No, thank you."

Ms. Horwath: OK, because when I attended the public meeting on this particular issue, it seemed to me that a big part of the gap was around parents' willingness—not necessarily willingness, but a level of awareness for moms particularly not only to not drink during pregnancy, but also to get involved with or attached to programs like Healthy Babies, Healthy Children. I don't think that every single mom and every single baby in every single community is connecting with that program. I come from the municipal sector, so I can tell you they're not. That's not to criticize the program—it's a great program—but it is to say that there are thousands of families that don't or won't or aren't able to, whether it's an income issue, a cultural issue, language barriers, whatever. Who knows what the issue is, but there are a lot who are not. How do we fill that gap and prevent this preventable disorder from happening? Maybe that's rhetorical; I don't know.

Hon. Mrs. Chambers: No. Part of our investment is to improve communication of these opportunities. We see them as opportunities. We're not prepared to mandate them. Having said that, I think as people become more comfortable, hearing from their friends that it was not as intrusive as they thought it would have been or something like that, there's a greater chance of it being more widely utilized.

Ms. Horwath: I guess part of the problem is that it's a stigma if you're going to be screened or you're going to be talking to a public health nurse about the fact that you drank during pregnancy and you could have caused a disability to occur in your child. I guess there are some pieces we need to get around to make sure that we find ways of talking about this that take the blame away and make it about how to make sure we can provide the supports that child will need over their developmental years and onwards, to be able to lead a full and productive life.

The Chair: I would like to recognize Ms. Di Cocco, please.

Ms. Di Cocco: First of all, I want to thank the ministry. One of the things that happened in my area with regard to children's mental health was that there was a program called Family Solutions that I believe was cut in 2002; it was removed. It was one of those preventive support systems that was shown to be really effective in dealing with some of the high-risk children and families. The program was funded again in 2003-04, I believe it was, and it meant a great deal in my community, because it certainly helped to provide that support system that looks at working out solutions in a preventive way with these high-risk families and high-risk children.

On another matter, in my former capacity as parliamentary assistant for children and youth, I learned a great deal about the variations and degrees of autism. One of the aspects that I learned was, first of all, the complexity in this spectrum, and as I said, there is a great degree of difference in the spectrum. I guess the most serious aspect for me was that I learned that this is increasing, and also that we really don't know what's causing the dilemma. But compounding our ability to deal with the service, with the need, was that we really needed to build capacity on many fronts when dealing with autism.

Again, I don't want to say the basket of services, but certainly it requires an art to be able to provide services to the families and the children.

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I guess what I'm asking the minister is—there are a lot of matters in dealing with capacity. There's a lot of need and it's growing. Because we understand there's a great need and that it's growing, we must be able to provide for the future in dealing with that increasing need. What are we doing and what programs are being developed so that we can fill that capacity? Could the minister enlighten me and the committee on what's happening there?

Hon. Mrs. Chambers: The matter of capacity building has its celebratory moments, because we know it's coming. It also gives me cause for impatience and frustration because, as you say, you can't just simply snap your fingers and have these resources available. But we have certainly started down that road.

The 100 students who are in the new college program now will represent—without any other growth in the system in terms of therapists coming from anywhere else, we will be moving from a current roster of about 535 or 537 of those instructor therapists in place right now. Like I said, there are supervisor therapists, there are program directors, but in terms of instructor therapists, just think, moving up from 535 or so, even if some people drop out of this program, we're talking about a potential for a 15% to 20% increase in the number of therapists by the spring of next year just from the addition of this program. By 2008, we're anticipating that there will not be 100 students but 200 students in that program. This is true capacity building. It's not short-sighted, it's not short-term, and neither is it compromising quality by just saying, "Anybody who thinks they have an idea of how to do this, come on board."

We have also recognized that we need to increase the level of expertise at other levels beyond the college program. We are funding grants for students who are interested in pursuing that at the master's level and at the doctoral level.

I should tell you, for the college programs, the grants that are available are up to $5,000; for the undergraduate and master's programs in universities, there are grants of up to $12,000 available; and for doctoral programs, there are grants of up to $24,000 available. As of the end of August this year, we've received 57 applications for instructor therapists, senior therapists and clinical staff. Twenty-four of these applications have already been approved and the remainder are being reviewed for eligibility. Again, that's capacity building.

You made reference to numbers growing and learning growing. We thought it was very important—and this is another thing that I had worked on with my predecessor when I was Minster of Training, Colleges and Universities. In the very near future, we should be in a position to announce the research chair.

There is actually not enough information on autism spectrum disorder out there. Like you say, it is a very complicated condition. This is why it's so important for us to recognize the importance of a continuum of services, the need for our children and youth to not simply have one kind of service and nothing before or after.

As someone else said, parents are going to have to live with these kids all of there lives. These kids need our support and the families need our support. There are a variety of supports that match the variety of assessments along this spectrum. It is in fact a very complex disorder, and it's really important for us to recognize that the supports required are longer-term as opposed to shorter-term. There are different types of supports that are known to be valuable, and through the use of consistent assessment processes and tools, we hope to get this to the point where we get this right for the children who need this kind of support. Somewhere in the order of about one in 160 kids is being diagnosed with autism or some kind of autism spectrum disorder, some of them more severe and some of them less severe. But again, I cannot emphasize enough the importance of recognizing that just as this is a spectrum disorder, we need to be able to provide for a continuum of services that in fact match the assessment of a child, not just once, but maybe every six months, periodically, to see how that child is progressing or not.

Ms. Di Cocco: Thank you, Minister, for that. My colleague will continue the questioning.

Mr. Wilkinson: First of all, congratulations, Minister. I'm sure it's exciting to be part of what I think people will look back on as being a historic ministry, because we are making a change that I think will be permanent in the policy culture of this province, to actually have a ministry dedicated to children and youth. I know that as you are busy picking from other ministries to try to get that ability for us to deal with all the issues that children and youth are dealing with, your managerial experience is going to come in handy over the next year or so.

Hon. Mrs. Chambers: Yes, every bit of experience.

Mr. Wilkinson: I couldn't speak to the minister without first of all just acknowledging and saying thank you on behalf of my constituents for the decision to increase the funding to the Rotary Respite House in Stratford, which serves families in Perth county with children with multiple disabilities. It allows these families to have their children spend a weekend away in a very warm and loving setting and give their family members a break, which is just so important when you have children with multiple disabilities. It's all designed, actually, to keep families together.

What I wanted to touch on are two issues, the first one being Best Start. I can report that when I made the announcement locally in St. Marys in front of our day-care centre, which was a former school, a not-for-profit centre run by the community, it was very well received. But my municipalities have expressed some concern about this—I know you addressed it AMO—their fear that they are going to do all of this, and of course we're in a hurry to get this done, and that maybe five years from now the federal government, which is such a valuable partner in this process, could turn around and change their opinion on this and they would be left with

this. I just wonder if you could share. I know you had quite strong opinions about this that you expressed at AMO about the need to get it right.

Hon. Mrs. Chambers: It is very important that we get this right. The planning that's underway right now with the October timeline is primarily about 2005-06, and there is more planning underway to take us beyond 2005-06 for the first three-year, $1.1-billion announcement. The full five-year announcement is $1.9 billion, but the first three years is the $1.1 billion. In 2005-06, the pressure is even greater, not just because there are families on waiting lists and not just because we want to prove that we can do this well, but also because the federal dollars for 2005-06 are actually in the form of a trust, so that when our municipalities are in a position to spend these funds, these funds will actually be disbursed. I acknowledge it's going to be difficult. For example, the funds are stipulated for capital and operating. Some of the capital initiatives that have not yet been defined would be rather difficult to get up and spending, if you like, as quickly as we'd like them to happen.

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I am not backing off, because I want our municipalities to be as aggressive as possible in terms of bringing forward plans. But should they be concerned about five years from now? I would say, worry about this year, worry about being as aggressive as possible this year, so that families can start to see that benefit this year and so that we don't leave any money on the federal table for this year. Now, come 2006-07 and 2007-08, we will not be dealing with in-trust funds. We will, in fact, be given a budget. The plans that are being worked on by the municipalities and our ministry now will be, if you like, more under our control to exercise and implement than the others.

We also announced that while traditionally municipalities have been required to share 20% of the cost of child care for the purpose of these dollars, the province is relieving them of that 20% share. In the first three years, that will represent $208 million that they will not have to spend. That would have been their 20% share. We had concerns that if we had to get 20% from them, it might detract from their ability to move aggressively on expanding these spaces and funding these extra spots. So I think it is a good-news situation and, yes, they are stressed; we are stressed. My counterpart, federal minister Ken Dryden, is a wonderful federal counterpart to have. I have spoken with him already about our concerns that we don't want to leave any of these federal dollars on the table. I don't want anyone to back off the aggressive approach to planning that I have asked for. Maybe that's also a reflection of my business background. But I think our kids need this and it would be very unfortunate if our families lost out on this opportunity to take advantage of these federal dollars in the first year.

Mr. Wilkinson: If we're successful over this five-year period, I think it would be almost politically unpalatable for any future government, whether here or there, to actually turn around and say, "That's something we're going to cut. We've had five years of success, but really, we have to get out of this." So success will breed, I think, the political will to continue this program, though it's only initially for five years.

Hon. Mrs. Chambers: Absolutely. When I had that discussion with Minister Dryden, he actually used the word "entrenched." So the municipalities, the province and the federal government are on the same page with this. We all want to see this work, because we want this to be permanent, we want this to be sustainable, and the best way to ensure that is, we think, like you said, to make it such a success that it would be unpalatable for them to withdraw this support.

Mr. Wilkinson: If I could just change the topic, I've had a number of constituents come to me about grandchildren of theirs who have been placed in protective custody, where the parent has lost custody. I might add, on a different topic but somewhat related, on behalf of one of the 72 families—one of them was in my riding; thank you for moving as quickly as you could to resolve that. It has meant a great deal to that family that mom has custody. She did the right thing to look after her child. It was heart-wrenching. You have to be Solomon in some of those decisions. She made the right decision, and finally we are able to support that.

Just going back to the question, I've had grandparents who have come to me. It's very difficult for them. You know, it's blood, it's their family. They feel that they should have the ability to plead a case to be able to look after their own family member. Obviously, their child is not in a position to look after the grandchild. That's obvious. In my own riding, where we were having a plague of crystal meth amphetamine problems, this is very important. Their children are being exposed to very dangerous situations. I applaud the children's aid society for being able to act proactively to save those children. But that doesn't mean that their parents, who are not addicted to this terrible drug, are any less fit. I think they are actually more qualified and can provide more stability for their grandchildren and still have that connection.

You've talked about some of the reforms you're looking at. Could you just help me with that question, about trying to have family members be given a greater priority if it's in the best interests of the child?

Hon. Mrs. Chambers: Absolutely. Certainly, I have also read some trenchant stories about grandparents, letters from grandparents who have said, "Had we known our grandchildren were up for adoption, we would have dearly wanted to play a role. We would have been happy to have them." As a grandmother myself, I don't know what I would do with myself if I were in that position. I just cannot imagine that kind of situation. Here it is, for whatever reason, the parents of the children have proven to be unable to take care of their kids, but there are grandparents who would like to be able to play a role there.

Bill 210 is what my predecessor, Minister Bountrogianni, introduced. First reading was June of this year.

The primary focus of Bill 210 is exactly what you're talking about: making adoption more flexible for children by allowing more children to be adopted while keeping important ties to their birth family and community; creating more legal options beyond traditional adoption so children and youth can be placed in a permanent home; making the process consistent for adoptive parents by simplifying the application process; and creating a province-wide registry to help match children with prospective parents and supporting families after an adoption.

I remember one of the early briefings I had after becoming Minister of Children and Youth Services. I looked at some of the numbers of foster care days and group home days, and they seemed to take up—I'm exaggerating a little—but it seemed to take up this amount of the line on the page, and then when it came to adoptions, it seemed to take up this amount of the line. I thought, "What's wrong with this picture? Is this the best that we're doing for our kids?" So I was pleased to have the opportunity to become more familiar with some of the issues that we are addressing through the proposed legislation, Bill 210, and I look forward to the continued passage of that bill through the Legislature.

The Chair: I'd like to recognize Ms. Munro.

Mrs. Munro: Actually, I want to follow up on the question that Mr. Wilkinson raised a moment ago. When I raised it in my earlier remarks, you mentioned in your response the amount of time that children spent in a foster home and how much better it would be if they were in a permanent setting, with which I agree, obviously. But the question I had when I raised the issue of making adoption more flexible—in your original comments, you talked about keeping ties with the birth family and the community. My question then, and I'll just repeat it, was that this is a significant departure in maintaining ties, because it's my understanding that one of the reasons why adoption has been slower to happen in this province is because of court-ordered visitations and things like that that had to come to some kind of natural conclusion, and then the child was able to be eligible for adoption.

All I want to know is where this kind of flexibility has occurred in other jurisdictions, and the success, in terms of increasing the rate of adoption, that has accompanied that.

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Hon. Mrs. Chambers: Well, what I can tell you—and I have made a note of your request for other jurisdictional types of information, which I don't have for you now. But what I can certainly tell you is that there are some children's aid societies that are doing a lot more in the area of adoption and there are some that aren't doing any. Some of it is that measurement that we spoke about, helping our children's aid societies to understand our priorities as a government and also providing some supports so that it will not be as difficult for them to consider—we're expanding front-end intervention and investigative options; we're delivering a continuum of permanency options; we're encouraging alternate dispute resolution as opposed to parents having to go to the courts all the time.

Incidentally, when I put my business hat on, I say that this will also free up money from those legal types of costs that we can spend on caring for our kids. It makes sense to me. I think, all around, it's a win-win opportunity that's actually going to serve our kids better.

Mrs. Munro: As I say, I'm not objecting to it; it was just a question of—

Hon. Mrs. Chambers: Why do I think it's going to help?

Mrs. Munro: Well, I think we all want the assurance that it's going to do what we want it to do.

I want to come back to the autism file for a moment. In the materials that were given at about this time last year through the auditor's process and the public accounts process—frankly, this meeting today coincides with a bit of an anniversary of that process—there were some very specific undertakings that the ministry had at that time. It seems to me that, given the complexity of this particular file, it's important for all of us to know what has happened in the meantime.

You have talked about the capacity ability, and having new staff and training programs, and I think that's appropriate given the kinds of problems that were evident. Two issues: One had to do with the data. It was made clear to us a year ago that there were discrepancies in the collection of data, and that was shown to us to be a major obstacle in being able to develop solutions to individual problems because of the problems which were inherent, simply by the fact that the ability to collect data uniformly was not there. I wondered if, first of all, you'd talk about where we are on the internal side of data collection.

Hon. Mrs. Chambers: Yes, you're certainly correct. One of the areas that the auditor identified was the need to improve our information systems. Incidentally, I've seen that elsewhere, and we're working on it. In fact, there have been dollars allocated in other areas, including children's aid societies, to come up with standard, consistent information systems. I will ask the ADM of this area to give further details, but it's fair to say that we have addressed the information requirements so that we do have better data. We have conducted training sessions as well, so that our staff and regional service providers understand what information we require. We are holding regular meetings with providers to give them the opportunity to share the information they have from their regions and report to us on progress that's being made in their particular regions so that programs can be managed more effectively. Even within our own ministry we have identified opportunities to share best practices, and that's well underway.

Deputy, if we could have the ADM.

Ms. Wright: Thank you, Mrs. Munro, for the question. I'll ask Trinela Cane, who's the responsible ADM, to come up and speak in more detail about what we have done on the information systems. Just to reinforce the minister's message on the seriousness of ensuring we

have good information, we're seized with it not only in the Ministry of Children and Youth Services; I was previously in the Ministry of Education and it was an equally important issue there. I think, from my short period of time here, the social service system is a little bit more fragmented and therefore has quite a few more challenges in terms of just the data collection. I have had an opportunity to read the auditor's report, and I think he's made some very salient recommendations.

I'll just have Trinela update you on where we are with it.

Ms. Trinela Cane: Thank you very much for the opportunity to respond. We have made significant progress in the area of data management and identifying our data elements and understanding what is going on in our program. The Auditor General's comments in this area were extremely fair. I think to some extent they recognize the complexity of the program that we're offering. To some extent it's a reflection of the speed with which we've proceeded to try to implement autism services for children and youth.

We operate currently with two information systems. One is called the service management information system, which the Auditor General noted, and ISCIS, which is the primary case management system currently used in the autism programs themselves.

We've taken some very stringent measures in this area. As the minister indicated, we worked very closely with our service providers because, without them, we cannot provide the types of data that are critical to the management of our program. We are continuing, perhaps too frequently for our own service providers, at least on a bimonthly basis to have regular contact on a series of issues.

In the first instance, with respect to the ISCIS, we actually upgraded our system in a fairly quick and dirty way last spring to deal with a number of irritants. One of those mentioned by the Auditor General was that service providers and clinicians completing the data entry could not correct errors on the system. That was a major irritant. We have not only improved and fixed that problem, we've met with service providers to identify a number of other irritants, which were also fixed as part of our upgrades in the spring.

The minister indicated that we've undertaken training. What we recognized with the turnover in staff and the number of new staff hired was that we had fallen behind in the area of training on ISCIS. The training has gone a huge distance, not only in terms of the system improvements that were needed in the short term, but to identify significant issues that have to be addressed in our system upgrade. We are planning a further system upgrade this fall and in the next couple of months. We've worked with service providers on the requirements and we will have a major implementation. It will also be accompanied by the training that's going to be required. I think one of the things we have to consider is our long-term plans for data management for this program, specifically with our information systems.

As we indicated last year, one of our major issues as we approach an integrated children's services ministry is to determine what systems requirements we'll have across the board.

The Acting Chair (Ms. Caroline Di Cocco): Thank you, and we now go to Ms. Horwath. These are 10-minute rotations.

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Ms. Horwath: There is one last thing I wanted to touch on and ask about in regard to the special-needs file. I figure with 10-minute rotations, it's probably best to do that rather than start to ask my questions around the Best Start program.

It's about the legal services, actually, and I think Mr. O'Toole raised some of those kinds of issues. I noticed on the organizational chart on page 9 of the estimates briefing book that the director of legal services branch reports—and it lists in order—to the ADAG, MAG and DMs of MCSS and MCYS. I'm just wondering, is there a significance to the order in which these ministries are listed? It seems to me there's a lot of concern around the litigation that's happening with parents. I know you're not in a position to actually talk about that in any detail, but I'm just wondering, who gets the crack at deciding who litigates first? Is it you as the minister or is it the Attorney General's office? What's the process?

Hon. Mrs. Chambers: I'm going to ask the deputy to address that.

Ms. Wright: Just by way of context, all legal directors across government report both to the deputy of the ministry that they're assigned to and to the AG. They all have a dual reporting relationship. On the very specifics of your question, litigation is managed by the AG.

Ms. Horwath: By the AG's office—

Ms. Wright: They are the lead in that sense. Sorry. I have a bad habit of interrupting.

Ms. Horwath: That's OK.

So they are the lead. That was important to me. I did know that it was a dual role, and actually it's set out right in the notes, so that's not the issue. The issue is, who is the decision-maker? The reason I raise it is because I can recall when the previous minister made some promises in the Legislature, if you want to call them that, around how this issue was going to be resolved, and then, lo and behold, found out that it couldn't be resolved that way. Mostly, it seemed like there wasn't a good connection, or at least the information wasn't flowing to the place that she was up to speed or as up to speed as perhaps the Attorney General's office was on this issue. So I thought it was important to raise that.

Having said that, again, it's not huge numbers, but I notice in the estimates briefing book on page 17 that the legal services budget is being bumped up by about half a per cent but much of the rest of the ministry's administration is being cut. It's a kind of bucking of the trend when you look at all the various budget lines there. I'm wondering, is there any particular legal issue that you see looming on the horizon and therefore thought you needed to bump up that particular line? Why was it seen fit to cut everything else but bump up legal services?

Ms. Wright: In general, there is a constraint across the administrative line, with the exception of legal, as you pointed out, Ms. Horwath. That is a redirection in the priority of service delivery, which the minister noted earlier. The slight increase in legal services is not representative of a looming legal issue that we are aware of. As you're fully aware, as I am, we're in a more litigious environment in general, which means that we talk to our lawyers quite a bit when we're doing policy and program delivery work. So it probably represents that as much as anything. But the actual litigation, as I said earlier, is out of the AG.

Ms. Horwath: If I can just continue on that, would it be fair, then, to suggest that some of the drivers that are causing a necessity to bump up that piece of the budget are some of the current lawsuits that are outstanding, let's say the charter challenge around IBI and those kinds of things? Are those some of the things that result in the need to bump up those budget numbers so that you can be sure to have resources to be able to deal with those cases?

Hon. Mrs. Chambers: I'd like to take this question, if you don't mind, Deputy.

Ms. Wright: Of course not, Minister.

Hon. Mrs. Chambers: I'm just so thrilled to have this new deputy, because I'm no longer the newest kid on the block. I am going to ask you to let me take responsibility for bringing you proper answers, as opposed to what we might think on the whole legal services budget. Would you let me do that?

Ms. Horwath: Sure.

Hon. Mrs. Chambers: Thank you. I'd appreciate that.

Ms. Horwath: On page 27, on the legal services budget again, it indicates pressure is coming from a line called "Services." What does that mean?

Hon. Mrs. Chambers: That was actually the question Mr. O'Toole asked and I made a note of that.

Ms. Horwath: And you were going to—

Hon. Mrs. Chambers: That's going to be part of that package.

Ms. Horwath: All right. That's great. That's fine.

Just to finish off some of the specifics around the IBI piece, you talked a lot about the plans to train more IBI therapists, but how many IBI therapists have been hired in this year—new ones, added to the roster this year?

Hon. Mrs. Chambers: I have that somewhere. I have seen it somewhere, because I was also interested in that. I will also commit to get you that information. What I can tell you is that in the last year we have doubled the number of transition coordinators from 13 to 26. Also, between April 2004 and June 2005, we increased the number of children receiving IBI by 39%. So, as at April 2004, 531 children were receiving IBI therapy; as at June 2005, 741 children were receiving IBI therapy. The ministry is actually collecting data now on—is it a quarterly basis?

Ms. Cane: Yes, quarterly information.

Hon. Mrs. Chambers: Yes, a quarterly basis, so it's almost time for another report to show up on my desk. We will be able to provide more up-to-date information in the very near future.

That does not answer the question of how many therapists were hired over the past year, but in the absence of having that kind of data for you, I thought it might be at least interesting to you to know what progress has been made in that area in the last year.

Ms. Horwath: Oh, absolutely. To follow up on that, do those data being reported to you on a quarterly basis include the related reduction in waiting lists? It probably isn't one-for-one, because we have more children, I think, on a regular basis identified as needing service. So it wouldn't be a direct proportion, I don't think, but would that report also indicate reduction in waiting lists or effect on waiting lists of some of these—

Hon. Mrs. Chambers: We do have a number of stats that we have been collecting and they do include the two lists: the wait list for assessment and the wait list for therapy.

I wish I could tell you that it would show the reduction in wait lists, because I don't know when we will get there. For example, in removing that age consideration, we know that the wait lists have in fact grown. That's why I say our capacity also has to grow.

Ms. Horwath: Absolutely.

Hon. Mrs. Chambers: So we are aware of that and it's a challenge that we are having to deal with. But I still think we're doing the right thing.

Ms. Horwath: And I appreciate that completely.

Is that quarterly report in any way accessible? Can I receive that or is there any way that I can have a look at that quarterly report?

Hon. Mrs. Chambers: I have learned a few things in government—

Ms. Horwath: So you can teach me, because I'm brand new.

Hon. Mrs. Chambers: —one of which is that there are no secrets.

Interjections.

Hon. Mrs. Chambers: Isn't that true? It's called transparency.

The Chair: If you're asking me, I just found it ironic that we couldn't get the expenses of the Minister of Health, but that's a painfully sensitive issue. Anyway, you did raise the question.

You have a minute left.

Hon. Mrs. Chambers: I can show you mine.

The Chair: Then, forgive me if I say you're transparent and we appreciate it.

Hon. Mrs. Chambers: Thank you.

I actually can tell you about staff hires between August 2004 and March 2005, after all. Shall I just go ahead?

Ms. Horwath: Sure.

Hon. Mrs. Chambers: Instructor therapists hired across the province are 110, clinical staff hired were almost four—it says 3.75; we may have to figure that out—let's say four, and senior therapists hired were 11. That speaks to the need to train more.

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Ms. Horwath: And to address some of the other issues around retention within the field.

Hon. Mrs. Chambers: Absolutely. Yes.

The Chair: Thank you, and the researcher has noted that that is a request. Can we have that go back from the period of time when the stats were first tabulated?

Hon. Mrs. Chambers: Certainly.

The Chair: Thank you very much; I appreciate that.

We have 10 minutes remaining, and I'd like to recognize Ms. Di Cocco, please.

Ms. Di Cocco: Thank you. By the way, I'm glad to note the minister's support for transparency. I actually have my transparency bill that I'll be debating tomorrow. It's an interesting topic.

One of the things I know is that it doesn't matter what age, whether a child is pre-kindergarten, kindergarten, school age, high school, university—I think one of the endeavours of government and society as a whole is to help that individual be the best they can be, at whatever stage that they're at. We've put in a great deal of resources and we have constantly discussed, in the past—and I go back to the days of opposition and before that, to this post-secondary and the need for that, and then your high school, etc. I would say that one of the transforming parts of our policy and what's happening in this ministry is the work that is starting to be done pre-school. I know that there's a notion, and I've heard this, "Well, maybe parents should stay home and look after their kids. We don't need to spend money in pre-school or early years." The reality is, and I think you pointed it out, that 70% of parents with children under five now say that they require some type of daycare. In my own experience, my children, the ones who have children, require daycare. Both of them work full-time. When I was raising my children, I had the privilege, or I was able to choose, to stay at home with them for a number of years.

Since that is the reality and it's not a matter of debate any more, whether or not we need early years education or daycare, I would like to understand better from you what the vision is when it comes to the Best Start initiatives that have commenced and are moving forward in the province. I think it is going to become a foundation, if you want, and a standard with which society in Ontario is going to look after its very youngest citizens.

Hon. Mrs. Chambers: I'm going to take this opportunity to correct something that I had said related to Best Start earlier on, and child care. My staff were listening and they want to make sure I get this right. This was in relation to the question of not-for-profits versus for-profits. I had said that 95% of child care spaces are in the not-for-profit sector right now. I need to correct that. It's 95% of child care spaces in the school environment that are in not-for-profit types of arrangements. My staff estimate that it's something in the order of about 80% overall of child care spaces that are in the not-for-profit environment.

I want to tell you a little bit about what the Best Start program will mean. We have talked a lot about early learning and child care. That would include the child care spaces—not just daycare; we're talking about a learning environment with an emphasis on quality and development for the kids, hence the college of early childhood educators. That's one of the areas where we also have an expert panel at work, and we're looking forward to receiving their recommendations.

We have the Healthy Babies, Healthy Children program. Ms. Munro made reference to that as something that's not brand new. That's true. We have added, though, to the budget for that program. We want to strengthen that. We added a few million dollars in 2004-05, and $8.35 million is what's budgeted for an increase in 2005-06.

We have the preschool speech and language program and the infant hearing program. I made reference to some of the results we're seeing there already, where we are doing a much better job at identifying these problems earlier. Remember, I mentioned the reduction in the average age of permanent hearing impairments being identified. Instead of at two and a half years old, it's now four months.

The infant development program: This is where we'd be looking at developmental disabilities or those at risk of developmental delay. The Early Years community supports and the Early Years centres would be perfect examples of that.

I have more than one Early Years centre in my riding, but I went to one's second-anniversary celebrations recently. They were telling me that they have such a huge demand for their programs that parents have to register ahead of time, and if they don't show up, not only do they get reprimanded, they are not allowed to sign up for a period of time following that, because what they're recognizing is that the demand is so great, it's just not fair, where there are limited-enrolment-type opportunities, for a parent to not turn up when another parent could have used the spot.

We talked about newborn screening. The director talked about this being universally available but not mandatory. We may not have talked about the follow-up phone call within 48 hours of the parent having given birth. We also talked about the 18-month screening program.

So, there's a lot going on there, and these panels are at work to ensure that we are doing this the right way. The expert panel on quality and human resources will have their recommendations to us by September of next year. The expert panel on early learning will have their recommendations to us by December of next year. The 18-month well-baby visit expert panel should be reporting within the next couple of months.

The college of early childhood educators initiative, we hope, will come forward in the winter 2006 session. Ms. Horwath is writing that down. I said, "We hope." Anyway, this is simply to say to you that we are forging ahead.

Some of the results to date from the Healthy Babies, Healthy Children program for the year 2004:

—92% of live births in Ontario were screened shortly after birth, out of a recorded 129,655 live births in Ontario;

—96% of consenting families with new babies received a phone call from a public health nurse;

—40% of consenting families with a newborn received a visit by a public health nurse shortly after leaving the hospital; and

—10% of consenting families received an in-depth assessment.

So this is picking up speed. I expect it to grow.

I remember when one of my sons—this was some time ago, now—came home from elementary school and called me at work. I was one of those parents who used child care—not subsidized, but used child care. My son came home from school one day and said, "Mom, I have a hearing problem." And I said, "I know. I tell you that all the time." But it really was serious, and it was a public health nurse in his school who identified that. It actually turned out to be very important, because what was diagnosed was hypertrophic tonsils and adenoids blocking the Eustachian tube to an ear, and the ENT specialist said that had that not been addressed promptly, the next time he had a cold, they could have become so inflamed that he could have suffocated. It got my attention pretty quickly. But it was a public health nurse in the school system who did that for us.

The Chair: Thank you very much, Minister.

Before we adjourn, are there any requests for information to be put on the record? I neglected to ask when we began, are there any specific individuals or agencies under the wing of this ministry whose attendance is requested? Mr. O'Toole.

Mr. O'Toole: Yes, I have a request for information in four areas, and I'll very briefly read them into the record, just one-liners:

1. What is the average annual cost to place a child in a CAS placement?

2. What is the average annual cost per person of therapy and/or treatment for autism?

3. What is the expected or planned budget for the child care plan or Best Start program? And last—I think this may have been requested:

4. Is the data available for wait lists for services in a number of areas—I think autism has been mentioned, but I don't think the data is available—but for other placements, such as adoption?

The Chair: OK. That's been noted, and if you have any of that now, we can have that submitted to the clerk. When we come back tomorrow at 9 o' clock, if you can give that material to the clerk immediately, he will have it photocopied for all of us.

This meeting stands adjourned until 9 o'clock tomorrow morning. We have approximately four hours remaining to complete these estimates. Thank you very much, Minister, and your staff.

The committee adjourned at 1602.

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