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Mardi 13 juin 2006

Standing committee on estimates

Ministry of Health
and Long-Term Care

Comité permanent des budgets des dépenses

Ministère de la Santé
et des Soins de longue durée

Chair: Cameron Jackson
Clerk: Katch Koch

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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON ESTIMATES

COMITÉ PERMANENT DES BUDGETS DES DÉPENSES

Tuesday 13 June 2006

Mardi 13 juin 2006

The committee met at 1548 in room 151.

MINISTRY OF HEALTH AND LONG-TERM CARE

The Chair (Mr. Cameron Jackson): Good afternoon. I'd like to call to order the standing committee on estimates. We are delighted to welcome the Minister of Health, the Honourable George Smitherman, and his deputy minister of long standing, Ron Sapsford, for seven hours of estimates. Minister, you're familiar with the procedure. We will commence with your opening statement. Do you have a copy of that statement prepared?

Hon. George Smitherman (Minister of Health and Long-Term Care): I have a copy for me. I think they must be out making that now.

The Chair: So we can anticipate copies momentarily.

Hon. Mr. Smitherman: It will be here.

The Chair: Thank you very much. Minister, we're in your hands. Please proceed.

Hon. Mr. Smitherman: Thanks. I want to make just one note off the top. Although the deputy has spent quite a number of years in service in the government of Ontario, he doesn't feel so far like this stint is long-standing, I hope, having done a pretty exemplary bit of work in Hamilton for a number of years. To us, he still seems like the new guy, refreshed and invigorated and bringing lots of good leadership.

Mr. Chair, committee members from all parties, members of the public, it's a privilege for me to once again have this opportunity to appear before the standing committee on estimates. The estimates defence process is a vitally important part of the what we do. All of us serve in the Ontario Legislature with the confident support of the people of Ontario—the people who elected us in our ridings across this province.

There are times when it may appear to some of these people that the work we do consists primarily of hurling rhetorical questions and answers at one another during question period. I think that it would be helpful if more people could have the opportunity to witness the work that's done in committee rooms such as this one. The work being done here is fundamental to effective government. It is amongst the most important things we do as legislators. So I am pleased, truly, to be able to be here to participate in this process.

I also commend and thank all members who serve on the standing committee on estimates and who have put so much time, energy and skill into this process. And I make a commitment that I will provide you with a thorough account of the work being done in my ministry and that I will seek to answer your questions fully and frankly; in fact, I'm looking forward to it.

One of the reasons I'm looking forward to it is that I'm very proud of what we've achieved over the past two and a half years. I'm proud of what our government has achieved and I'm very proud of the progress that I've been a part of in the Ministry of Health and Long-Term Care. I'd like to use my remarks today to review some of what we've done in the health portfolio and I'd like to look ahead and tell you how our work will continue. I think it's a pretty compelling story.

I think it will also be apparent that our work is part of a coherent plan in pursuit of a clear vision. Sometimes that day-to-day work we do gets lost in the clutter of various announcements and initiatives. It's often difficult to see the coherence of the changes being made. But when one steps back and looks at the reforms we've made in the area of health care, it's evident that there is a very clear set of goals and principles driving our work. In fact, I would argue that it is very difficult, if not impossible, to undertake far-reaching reforms without a clear vision to guide you. Without a clear vision, changes can be disruptive, even counterproductive. In order to make real progress on the big issues, a clear vision, a clear set of goals at the outset is imperative.

So let me take a moment to tell you about our government's health care goals and vision. Our vision is of a health care system that keeps Ontarians healthy, provides them with quality care when they're sick and is sustainable—a system that will be there for our children and our grandchildren. These goals may sound obvious, perhaps even simplistic, but the truth is that we haven't always made decisions with these principles in mind. Keeping people healthy, for example, has often been overlooked. We've often tended to think of health care as something reactive, as something we do after someone has become sick or suffered an accident. To shift part of our focus to keeping people healthy, being proactive rather than reactive, represents a profound shift.

One sign of our government's commitment to this goal is the fact that for one year now we've had a Ministry of Health Promotion, dedicated exclusively to keeping Ontarians healthy. Under the leadership of the Honour-

able Jim Watson, the Ministry of Health Promotion has already done remarkable work. Let me be clear: The goal of keeping Ontarians healthy is not a feel-good exercise; it's a vital part of building a health care system that is sustainable. Preventing illness in the first place reduces the pressure on every other part of our health care system. It allows our doctors, nurses and hospitals to work more effectively, and it allows us to allocate resources more effectively.

The second part of our vision is a health care system that provides Ontarians with good care when they need it. Good care when they need it: not mediocre care, not quality care when they can afford it, but good care when they are sick and need it. Again, that may sound obvious, but to actually make a commitment to this means making some tough and determined decisions. Our government has made a commitment to this goal, and we've been making those tough decisions.

Finally, the third part of our vision is a health care system that's sustainable. And the sad reality is that our health care system only a few short years ago was on a very fragile footing. Building a sustainable system means, again, making tough decisions—tough but necessary. And again our government has been making these. On that issue I'm very pleased to be able to report that our progress has been substantial.

Just a few short years ago, the projected cost curve for health care spending was frightening. Annual increases in the range of 8% to 9% were barely tenable in the short term and utterly unsustainable in the medium and long term. We've gotten this cost curve more under control. Yes, health care spending continues to rise, but the decisions we've made, the reforms we've introduced and the discipline we've imposed have flattened this cost curve. For 2006-07, we've succeeded in bringing this cost curve down to a 5.7% increase. I know I don't need to explain to anyone on this committee how significant an achievement that is.

We certainly didn't achieve this on our own, so let once again express our thanks to the dedicated women and men on the front lines of health care: our doctors, nurses, hospital administrators and health care professionals throughout the province who have helped with this difficult but vitally important job.

Keeping Ontarians healthy, providing them with quality care when they're sick, and building a health care system that's sustainable, one that will be there for our children and grandchildren: These three goals anchor our vision of health care.

There's one element which is a central part of our vision. It's this: We believe in public health care, in medicare. There are a lot of people with a lot of different solutions to our health care challenges, but unlike some other provinces that have chosen to permit private health care to chip away at the public system, we are determined to protect and to enhance medicare.

But let me be very clear about one thing: Protecting medicare does not mean embracing the status quo or resisting change. I would argue the exact opposite: In order to protect medicare, change is essential; innovation is absolutely necessary; reform is crucial. And that's exactly what we've been doing: moving forward with an agenda of change, innovation and reform in order to preserve and strengthen medicare. So let me tell you in more specific terms what we've been doing and what we propose to do in the months to go.

I'll begin by addressing our changes to Ontario's drug system. During the past month or so, you've probably heard some discussion about this issue; in fact, many of you, of course, have been involved in it. Allow me to explain exactly what we're doing and why.

First off, our objective is very clear: We want good value for taxpayers' dollars. The way we get better value is multifaceted. We need to make our drug system more efficient, we need to make it more accountable and transparent, we need to get better pricing—pricing that reflects the enormous volume of drugs that we purchase. We believe Ontarians deserve a drug system in which patients get better access to the drugs they need and taxpayers get better value for the money that we spend—a system that is fair to retailers, to pharmacists, to doctors and to manufacturers.

With these goals and values guiding us, we developed a comprehensive set of reforms based on recommendations from the Drug System Secretariat that we appointed in 2005 to review the system. The secretariat held more than 100 meetings with more than 350 stakeholders. What the Drug System Secretariat found was that there were huge opportunities to improve patient access to drugs and for Ontario to receive better value for the money we spend on the provision of prescription drugs.

As you know, we've introduced Bill 102 to improve the province's drug system for the benefit of Ontario's patients and to use all gains to enhance their access to drugs and the help they get to use them. The public hearings on this bill were very constructive, and Bill 102 is currently before the Legislature, to be called soon for third reading.

Under the heading of "Keeping People Healthy," I mentioned that we've made some remarkable strides. One of the initiatives I'm most proud of is the steps we've taken to combat the deadly effects of tobacco. Together with the Ministry of Health Promotion, we launched the toughest and most comprehensive anti-tobacco strategy in North America. As you probably know, just a few short days ago, on May 31, the Smoke-Free Ontario Act took effect.

As a result of this bill coming into force, smoking is now banned in all workplaces and enclosed public spaces, including restaurants, bars, schools, private clubs, casinos, sports arenas, entertainment venues, enclosed smoking rooms, work vehicles and offices. The Smoke-Free Ontario Act also toughens the laws on tobacco sales to minors. And two years from now, on May 31, 2008, it will outlaw the display of tobacco products in stores, finally eliminating the so-called "power walls" used by the tobacco industry to aggressively advertise their

products to everyone who steps into a corner store or a gas station. And I want to acknowledge the good work of my colleague from Ottawa on this very particular issue. I'm very proud of this law. My only regret is that Heather Crowe, who helped so much in moving this issue forward, wasn't alive to see this law come into force.

Keeping people healthy also means making appropriate targeted investments. That's why we're working hard on Operation Health Protection, an action plan to revitalize Ontario's public health system. And our investments in public health tell a very clear story.

In 2006-07, we will be investing an additional $110 million in funding for public health mandatory and related programs. This amount includes $60 million from the Ministry of Health and Long-Term Care and a further $50 million from the Ministry of Health Promotion, and we're well on track to fulfilling our commitment of covering 75% of public health funding by 2007, uploading these costs from the municipal taxpayer base. These are significant investments, and they will yield important results for the people of Ontario.

Keeping people healthy also means providing enhanced access to health professionals: doctors, nurses and other health care workers at the local level. And that's happening through such initiatives as our interdisciplinary family health teams.

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Family health teams embody true collaborative care that not only benefits patients, but also helps relieve the pressure on hospitals in terms of patients staying healthy, receiving care close to home, and focusing on individual and population health needs. I truly believe that family health teams represent the future of health care here in this province and elsewhere. Because of the support family health teams receive from the other professionals on the team, doctors working in a family health team model can extend care to more patients per doctor than those doctors who work alone. They can also provide a broader range of care and programs, like diabetes, mental health and heart disease.

Earlier this year, I was very pleased to announce our third wave of family health teams, bringing the province-wide total to 150, as we've committed. These are coming to life in 112 communities. To date, 41 family health teams are now fully operational, and another 65 business plans have now been submitted. This is very encouraging. These are community- and provider-driven plans that are not "one size fits all."

Some naysayers have complained that family health teams exist only on paper and that they're not operational. I must say that that would come as a surprise to the 67,000 patients in family health teams who have been readopted. These are patients who, prior to the evolution of family health teams, were not connected in any form of our primary health care initiatives in Ontario. That number is going to grow.

We're also investing in primary care physicians, bringing their salaries closer to those of specialists, but the important point to remember is this: The investments—the very substantial investments—we're making in primary care are the foundation for the results, the successes, we're seeing elsewhere, like reductions in the number of orphan patients and less pressure on the acute care sector.

As I said at the outset, we have a coherent and cohesive plan, and all of our changes are stepping stones to the goals we've identified. This is one more example of that. Another part of the equation is creating more doctors and nurses. We've been very active on this front as well, and once again, while more doctors and nurses is a very good thing, it's also a very big step towards achieving our goals of fewer orphan patients, for example.

Recently, we launched our HealthForceOntario health human resources strategy, one of the most important health initiatives ever undertaken by our government. For the first time, Ontario is now developing a coordinated, competitive and innovative approach to planning for health human resources in the province, and as we progress with this plan we'll address the serious shortage of health care providers over a period of the next five to 10 years.

We will, of course, train as many health care providers as we can here in Ontario, but we know that our training capacity still won't turn out the right numbers of people we need to give Ontarians the right mix and the number of providers when and where they're needed. The HealthForceOntario strategy is centred on retaining the health human resources we have, on convincing those who have left the province to return and on attracting new health care workers.

We're encouraging doctors, nurses and allied health care professionals across North America to choose Ontario as the best place to pursue their careers. We're also increasing undergraduate medical school enrolment by 23%. That equals 160 spaces by 2008-09, fulfilling a much greater number than the commitment that we made in the election of 2003.

In 2008, there will be 852 first-year medical school spaces available in Ontario. We're also investing $43 million between 2004 and 2008 to increase the proportion of residency positions allocated to family medicine. The good news is that doctors in Ontario want to be family doctors again. This initiative will see 141 new family medicine training positions established by this July and will create 337 additional family doctors by 2008. Both Canadian medical graduates and international medical graduates will fill these new seats.

Let me say a little bit more about foreign-trained doctors, because they represent a vital part of the solution to physician shortages in underserviced parts of the province. Since the fall of 2003, when we came to office, the international medical graduate program has led to an additional 86 doctors currently practising in Ontario's underserviced communities. Another 287 are currently in training programs, and the first of these graduates will begin practising in underserviced communities this year. This fall, I'm very pleased to tell you, we have accepted

another 217 candidates through our IMG program, surpassing our annual target of 200.

Patients throughout Ontario have a right to timely medical care when they need it, and these foreign-trained professionals help ensure that that care is available. That's why we've invested $39.5 million in training for our foreign-trained doctors, making Ontario the leader in Canada by far when it comes to providing support for the assessment and training of international medical graduates. Again, it's results that matter and results that speak loudest.

Today, more patients have access to the medical care they're entitled to. Today, more than 90% of Ontarians report having a regular family physician, and 90% of Ontarians are satisfied with their access to primary health care. It's also very encouraging to see that the number of orphaned patients is declining. I'm confident that we will be in a position to provide more details on the progress we're making with respect to orphaned patients very soon.

Let me speak briefly about nurses as well, because they too are a vital part of our health care equation. I'm delighted to report, and will hand out paperwork shortly, an update on the numbers on our progress towards creating 8,000 new nurses. We have, to date, created 4,299 new nursing jobs in Ontario. I know that the estimates process generates a lot of numbers, but this is an important one: 4,299 new nurses working in communities, hospitals, long-term-care homes and public health units throughout the province; 4,299 new nurses helping to provide care as only nurses can.

This is a huge achievement and one that we're very proud of. It represents a very significant increase from the 3,052 nurses that we had identified at estimates last year. Our projections indicate that we are on track for 2,513 more nurses this year and next. Ontario's a good place to practise nursing, and that's good news for Ontario patients.

A vital part of delivering quality care to people when they need it is making better use of facilities like community health centres. Community health centres provide front-line health care to people who face barriers like language, culture, physical disabilities, homelessness or poverty. Ontarians who use community health centres have access to doctors, nurses, nurse practitioners, social workers and other health care professionals working as a team. Of course, we've dramatically expanded the number of community health centres in the province of Ontario.

Personal support workers will benefit from an increase in the minimum base wage from $9.65 an hour to $12.50 an hour, and will receive access to benefits and compensation for travel time and mileage.

The home care workforce as a whole will have greater workplace stability through measures like extending CCAC contracts with home care agencies for up to nine years.

For countless people a crucial measure of our health care system is wait times. As you know, we're working hard to improve timely and appropriate access and to reduce wait times for five major health care services, including MRI and CT scans, hip and knee joint replacement, cancer surgery, selected cardiac services and procedures, and cataract surgery. We've seen some remarkable success. The simple truth is that wait times are down. We measure average wait times, median wait times and what we call "90% completed within" wait times. That's the figure for how long it takes for 90% of people to receive the procedure that they need. This 90th-percentile figure is a much more meaningful number than an average or median as it takes into account the real-life experience for 90% of our patients.

Let me quickly share with you some of these "90% completed within" numbers. Wait times are down: 41% for angiography—that's 23 days; 26% for MRIs; 25% for angioplasty; 16% for cardiac bypass surgery; 14% for CT scans; 10% for knee replacement; 6.4% for cataract surgery; 4.3% for hip replacement; and 3.7% for cancer surgery.

These numbers are not celebratory on their own. It is when we consider that many of these were on the rise that we really learn the true effect. We have reversed the trend lines and we have reduced the wait time for patients all across Ontario.

What's important, of course, isn't the numbers or the percentages, but what these reductions mean for real people, for the patients we work on behalf of: a new lease on life for a cancer patient, new mobility for a senior suffering from hip problems, results from a CT scan to relieve a patient's anxiety or enhanced vision from a successful cataract surgery.

Let me give you one more number, a number that puts this achievement into a patient context. As a result of the improvements that we've had in wait times today, we've eliminated 3.3 million days of waiting for Ontario's patients—3.3 million days. That's what our strategy is all about: real results for Ontarians and their families.

Our data also demonstrates that there are some instances where wait times have not budged or may even be up a bit, and that too is part of the value of this exercise. It allows us, for the first time, to have this information, and it's available for all to see on our wait-times website, a site which has already had more than one million hits.

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Identifying problems or bottlenecks allows us to take quick action to correct them, which is exactly what we're doing.

Smart Systems for Health's network also allows us to gather and share more accurate and useful data. We all know that information technology projects are complex and costly, but they are a crucial building block, and we remain 100% committed to Smart Systems for Health.

Another file on which we continue to be very active is long-term care. The increase in base budgets for long-term-care homes since we took office is $740 million. We've taken steps to ensure stability in the long-term-care workforce and to increase the per diem for food so

they can now keep pace with the consumer price index and are consistent with the rate of inflation.

Today we have 3,140 new full-time equivalents employed in our long-term-care homes, 682 of whom are nurses. We've also made a very deliberate decision to treat long-term-care homes as homes, not facilities. This is more than just a change in language; it represents a fundamental shift in attitudes and it helps to drive the culture that we want.

Soon we will be introducing long-term-care legislation. While I'm not in a position to foreshadow all of the reforms contained in this legislation, I can tell you that we will improve and strengthen our province's vital long-term-care sector.

Building a more accountable, responsive health care system also requires some fundamental changes to the way the system is structured and administered. One of the goals behind a lot of our work has been to build a true system, a system to better manage the delivery of hospital and other health services.

Local health integration networks are a big part of the structural change necessary to achieve this. Local health integration networks will provide an integrated and patient-centred health care system, one that's responsive to local health care needs. Once they're fully operational, they will plan, coordinate and fund health services—from hospitals and long-term care to home care and mental health services—allowing greater community involvement in local health care decisions.

About a year ago we launched the LHINs as 14 corporations, complete with board chairs, board members and CEOs. Bylaws for each LHIN were enacted, performance agreements were established, MOUs between the ministry and the LHIN were signed, and comprehensive governance policies were developed and implemented across the LHINs.

Last August, LHINs started working with the communities they serve, and last fall, LHIN offices were set up and opened for business. Now, local health integration networks are developing integrated health service plans which are scheduled for completion by this year.

LHINs are working with the local community and health care providers to set priorities and to plan health services in their area. They'll then move to integrating and coordinating local health services and eventually to determining and providing funding and resources.

LHINs represent a change in the way health care services are delivered. They also represent a big change for the Ministry of Health, in which I serve. By shifting this kind of power to LHINs—and I'm talking about more than $20 billion in real spending power—the role and responsibility of the ministry is undergoing a fundamental change.

Once LHINs are fully up and running, the ministry will be able to refocus its efforts on what it should be doing, things like establishing overall strategic directions and provincial priorities for the health system; developing legislation, regulations, standards, policies and directives to support those strategic directions; monitoring and reporting on the performance of the health care system and the health of Ontarians; and planning for and establishing funding models and levels of funding for the health care system.

In essence, the Ministry of Health will be less involved in the day-to-day delivery of health care and more involved in establishing overall direction on policy, priorities and investments. We promised change, and that applies to us as well. And this certainly represents a change.

I hope that during the course of estimates you might ask questions of the deputy minister about the ambitious reform that he's brought forward to the structure of the Ministry of Health itself.

We seek, at the Ministry of Health, to rise up to a more strategic plane, to ask those closer to the action to be more involved in much of the day-to-day management, so that our focus can be appropriate on issues that are fundamental to the survival of our public health care system in Ontario, a health care system that does a more adequate job of projecting our needs with respect to health human resources, that does a better job of providing leadership around issues like information technology.

It's also important to view the introduction of LHINs from a business perspective. Anyone who's been active in the business world knows that you just can't appropriately run a $35-billion operation from head office. You can try, you can shovel the dough out the door, but you can't be certain it's going to get the best effect.

I must say it astonishes me when some members of our assembly, especially those with high-level corporate backgrounds, insist on digging in their heels and resisting this obvious and positive step. If it's good enough for shareholders, it should be good enough for taxpayers. After all, this is their health care system. They're the ones who pay for it. They deserve the best with respect to care and they deserve the opportunity to truly influence the health care system in the province of Ontario.

Of course, hospitals continue to be an essential part of our health care infrastructure, and I'm very pleased to report that things are good and getting better. The steps we've taken to enhance community-based care have taken some of the pressure off hospitals. We continue to provide them with stable long-term funding, and the ministry has a strong, positive working relationship with hospitals, a relationship anchored by the $600 million we're investing—that's new money—in hospitals this year. Our 90-10 cost share formula recently announced, whereby the province of Ontario will provide 90% of the cost of construction so that hospitals can focus their fundraising resources on the remaining 10% and on equipment, is a real commitment that provides stability and security. One hundred forty of Ontario's hospitals have entered into accountability agreements and are on their way to balancing their budgets, and we continue to work on a case-by-case basis with those 12 remaining hospitals.

I think patients throughout the province can celebrate the fact that Ontario's hospitals are today on a much

stronger footing than at any point in recent memory, and I'm delighted to see that hospitals large and small have embraced our message of innovation.

Continuing with the good news, there have been remarkable strides forward with respect to mental health. The investments we've made are resulting in better care, and the results are there for all to see. I'll share just one statistic with you, but for me it's a very meaningful one. We knew, when we began our reforms with respect to providing more proactive mental health services for people in the community, that 37% of all of those engaged in the criminal justice system were people identified as having challenges with mental health. We know that a lot of people with mental health challenges were simply remanded, put in our jails, because they had no place to call home. The number of people with mental health problems currently on remand has been significantly reduced. In the Scarborough court, just as one example, in less than a year, remands are down by 36%. The criminal justice system isn't the place for people with mental health problems, and finally the provincial government is taking the necessary steps to get people the care that they need.

We're getting people with mental health problems into apartments through rent supplements, which in some cases are being very creatively leveraged. Our mental health reforms are also getting people out of hospital emergency rooms and into programs more suitable for them. It's remarkable when you think about it: In two and a half short years, we've introduced reforms that have focused on community-based care and significantly reduced the burden on hospitals. That's something we can all celebrate.

Our colleague from the great riding of Mississauga West is here, which includes Credit Valley Hospital, a hospital in a growing community that actually had a reduction in the number of people coming to the emergency room in search of care. Those are the things that we must celebrate in health care in Ontario.

Before I conclude, let me also say a little bit about another concept that is central to what we're doing, and that's accountability. We believe it's time for Ontarians to take ownership of their health care system. After all, as I said before, they're the ones who pay for it. We want them to become more involved in decisions about health care and to assume greater responsibility for their own health and well-being. Let's face it: This accountability hasn't always existed. That's largely because it simply wasn't possible for people to get accurate and timely information about health care. Innovations like our wait-times registry are a big part of correcting this, but accountability also means putting in place mechanisms to provide ongoing and independent proof that Ontarians are getting a system that delivers the best possible quality of care.

To that end, we're ensuring independent and public reporting of results in improvements in the delivery of health care, as well as establishing accountability in the system through innovations like the Ontario Health Quality Council. To put it simply, we believe that Ontarians deserve a clear accountability framework, including third-party verification within the health care system.

In conclusion, let me once again reiterate that the driving objective behind the reforms we've introduced is straightforward: to better serve the people of this province. That's the only criterion by which we can judge our success or failure, and that's the goal my colleagues and I in the Ministry of Health and Long-Term Care strive to meet. When one looks at what we've achieved, I think it's fair to say that we're making big strides towards that goal. In the months and years ahead, I am confident that we will continue to make progress.

I thank you for your attention and look forward to the considerations through the course of this committee's work. Thank you very much.

The Chair: Thank you very much, Minister. You're dead on time, pretty well—exactly. Well done.

In accordance with our practices, I will now recognize Ms. Witmer for up to 30 minutes.

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Mrs. Elizabeth Witmer (Kitchener–Waterloo): Thank you very much. I'm going to go into questions.

The Chair: It's your time.

Mrs. Witmer: I'd like to take a look at the hospitals. I'd like to reference the announcement that was made by the government on June 9 that it would now cover 90% of the eligible construction costs, and this would result in an additional $1 billion of support coming from the province. This would apply, I guess, to all hospitals that had not gone to tender as of April 1, 2006.

I'd like to know where and how the government freed up this $1 billion for this new cost-share policy. Where would I find it in the estimates book?

Hon. Mr. Smitherman: If I make a misstep here, the deputy will assist us. Largely speaking, I think the estimates for this item—it's an announceable on behalf of the Ministry of Health but the estimates would come primarily from the capital budget of the government of Ontario through the Ministry of Public Infrastructure Renewal.

Mrs. Witmer: So then this is not an increase in funding from the Ministry of Health but from ReNew Ontario?

Hon. Mr. Smitherman: Some of the capital projects in the Ministry of Health are done in the traditional form, and those are in the capital budget of the Ministry of Health, and some of them are through the Ministry of Public Infrastructure Renewal. So there are capital projects that come from those two different pools, but it's an announceable on behalf of the Ministry of Health, which finds its funding source in the capital budget of the Ministry of Public Infrastructure Renewal.

See if the deputy has any further clarification on that.

Mrs. Witmer: So it's not new money; it's simply a shift.

Hon. Mr. Smitherman: Oh, no. It's absolutely new money. It required the Ministry of Public Infrastructure

Renewal to go back to the cabinet for additional allocation.

Mrs. Witmer: Deputy?

Mr. Ron Sapsford: Most of the additional funds, though, will be in future years—I want to point that out—as opposed to in the current estimate. So it's a policy that applies forward as capital projects are brought into line.

Mrs. Witmer: That $1 billion will be allocated over how many years?

Mr. Sapsford: At least five—longer than that. The current program is at least five years long, and the additional cost sharing would be spread out over the life of all those capital projects.

Mrs. Witmer: Could you give us the specific timelines over which the $1 billion in support that would be flowing to the hospitals would cover?

Mr. Sapsford: I'll undertake to do that.

Mrs. Witmer: I'd like to have a list of the projects that are going to be included.

Hon. Mr. Smitherman: The one thing we need to offer as a caution in terms of what we will be providing, is that the Ministry of Public Infrastructure Renewal—of course, these are based on projected estimates of cost for projects on an outward-looking basis. You would know very, very well from your experience as Minister of Health and also locally that these are subject to confirmation through the tendering process and to the actual cost of construction. But we'll work to provide that information, recognizing that it's on a forward-looking basis.

Mrs. Witmer: Right. At this point in time you must have some idea as to what projects would be covered under the $1 billion that's basically being shifted around.

Have you done an analysis to see what impact this is going to have on the community? Because at the same time you're downloading new equipment and replacement equipment, I understand, to the hospitals.

Hon. Mr. Smitherman: The net benefit to the hospitals will be quite considerable. We'll offer that to you. To call that a download is an interesting use of a word that you guys invented as a policy. But I think the reaction of the Ontario Hospital Association does speak to their understanding that this is taking a significant cost share off of the back of local communities. It's in reaction to or a reflection on the reality that, especially through some of the larger projects, local communities are really struggling to be able to advance all of the necessary local dollars.

The mechanism of allowing hospitals, from the standpoint of their fundraising, to focus on equipment creates more discernible bite-sized chunks, which they think is very, very helpful in terms of being able to reach out to individual contributors, and also allows them to spread their equipment purchases over a period of time in order to be able to make sure that their local commitments are met. For all of those reasons, we have seen very enthusiastic response to this policy from the Ontario Hospital Association and from hospitals all across the province of Ontario.

Mrs. Witmer: Are you able to give us examples of all of the types of equipment and other furniture needs or whatever else is now going to be, I would have to say, downloaded? Because it is; it now becomes the responsibility of those hospitals. I'd like to know exactly what costs—somebody must have done a cost analysis when the decision was made to shift the share of funding to 90% across the board and, at the same time, download this responsibility. Do you have an analysis? What sort of analysis did you do in order to arrive at this decision?

Hon. Mr. Smitherman: We'll be happy, as the deputy has already indicated, to share all that is available. I just want to remind the honourable member, who may not recall all of this from her days as Minister of Health, that local communities are always quite involved in determining their own equipment lists. There were some things that were cost-shared and some things that weren't. There are alterations to those policies, and we would be very happy to share them with the honourable member.

Mrs. Witmer: What about hospitals that have already raised their share—and there are some—that are now going to be getting the 90%? What's going to happen with the money that they've already raised?

Hon. Mr. Smitherman: It's really best to be determined on a case-by-case basis. We need to look at the circumstances for each and every one of those hospitals. There is no expectation on our part that we would get involved in altering any of the arrangements they've made with their local communities around fundraising. It may, in some cases, provide some of those hospitals with greater flexibility than they had going in, but I do think that the important note here is that the alteration to the policy is designed to ensure that hospitals are not being opened in Ontario where the local community's share has not been able to be raised, which has the effect of asking hospitals to carry debt for which they have no servicing capacity. Increasing the proportion to 90-10 has the effect of ensuring that, especially on those larger builds, hospitals have a greater capacity to support them.

We've seen, in a wide variety of communities, including some of those represented by members who are before committee today, where the community's capacity to raise the local share has really been quite challenging. We do think that this will assist those communities. The implication of increasing the share to 90% and how that works in terms of fundraising efforts that have already been deemed successful would really be, like I said, on a case-by-case basis.

Mrs. Witmer: What about a hospital like Cambridge or Woodstock? What's going to happen with those hospitals? Those are projects that we had announced and you delayed and you have now re-announced. Are they going to get the 90% funding?

Hon. Mr. Smitherman: The difference is, you announced them; we're actually going to build them and fund them. You announced them.

Mrs. Witmer: Are you going to be funding them 90%?

Hon. Mr. Smitherman: The application on the Cambridge situation—this is a policy that applies after April 1, 2006. Obviously, some tendering and construction work at Cambridge has been initiated, so I rather suspect that it will be a bit of a hybrid. Some might, some might not and some will, on a going-forward basis, of course—this policy would apply.

In the case of Woodstock, I believe that the new policy would apply, yes.

Mrs. Witmer: I think you've indicated that construction will not begin until 2007-08.

Hon. Mr. Smitherman: Yes, so obviously the community of Woodstock will benefit. Perhaps somebody could pass me up a note and I'll give you the expected benefit to a community like Woodstock from an alteration of the policy.

Mrs. Witmer: And that will also take into consideration the downloading that is a result of this new policy too?

Hon. Mr. Smitherman: As we've already indicated to you, we will provide you with a broader range of information.

Mrs. Witmer: You're going to provide me with a list of all of the hospital projects that are part of your government's health infrastructure investment plan from now until whatever announcements you've made. I'd like to know which ones are going to be the beneficiary of this 90% share from the province.

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Hon. Mr. Smitherman: We'll happily do that. I doubt that will be this afternoon.

The implication for Woodstock on the alteration of that policy is greater than $30 million.

Mrs. Witmer: How much are they going to have to incur in costs for the part that was downloaded?

Hon. Mr. Smitherman: That part is, in a certain sense, up to them, as they work towards the fine detail on their equipment policy. As I've already indicated, we'll seek to answer those questions for you as we go forward.

Mrs. Witmer: I wonder if there's somebody in your staff who is sitting here who could give me some estimation of what it costs to equip a hospital and what costs hospitals are now going to incur that will no longer be funded by the province.

Hon. Mr. Smitherman: You have to look at all these things on a case-by-case basis. There are no two ways about it, and that's always been the case, including through the three years that you served as Minister of Health. Of course, fewer projects were going forward at that time, but as you had the opportunity to look at equipment, you have to consider its age. There's a wide variety of circumstances that are influenced there, and I don't think that there's a stock answer. We can obviously work to provide you with as much information as we have, and the deputy will have some more information available to you, but I don't think there's a stock answer, because it's not like everybody started at the same starting point and got renewed 30 years later or what have you. It's a hodgepodge out there that really does require quite a lot of consideration on a case-by-case basis.

Mr. Sapsford: In general terms on capital projects, though, the equipment portion can run between 12% and 20%, as the minister said, depending upon the specific situations. So the impact of the change in this policy is that 50% or 70% of total costs versus 90% of construction, and then the balance in the hospitals of 100% for equipment, generally ends up as a smaller proportion for the hospital to pay. So the money they've been raising as their share of 50% of the capital construction, or 70% depending upon the type of project, is usually more for the hospital to pay than 100% of the equipment. That's the basis on which the policy shifts.

You should also bear in mind that hospitals are responsible for paying 100% of equipment now for replacement equipment, so much of their fundraising activity is geared towards raising money for equipment. Hence, this policy is consistent with the role that hospitals and their foundations are already playing.

Mrs. Witmer: What is the latest hospital project that you have announced?

Hon. Mr. Smitherman: Gosh, there have been so many. It could have been the Pickering-Ajax project. I'm not sure if it was the Queensway-Carleton or the Montfort—

Mrs. Witmer: What year would that be?

Hon. Mr. Smitherman: How many years forward?

Mrs. Witmer: Yes.

Hon. Mr. Smitherman: The plan has been a five-year rolling forward plan, so it would be the out-years—five from now, 2009-10.

Mrs. Witmer: So where would I find in the estimates the amount of money that's been set aside for those hospital projects?

Hon. Mr. Smitherman: You've already asked for some of that information. I suspect that this is also through the planning budget of the Ministry of Public Infrastructure Renewal.

Mrs. Witmer: Is there anything in the estimates here for those hospitals?

Mr. Sapsford: For the current year, probably not. There may be some planning dollars, depending upon the type of project that's been announced. If it's being funded as a standard granting project, then presumably there would be planning money in these estimates. If it's being dealt with as an alternate funding approach, then there won't be any dollars in the current estimates. They would come in future years.

Mrs. Witmer: What's happened to a hospital like Runnymede? Is there anything happening there?

Hon. Mr. Smitherman: Runnymede hospital is a project that is under very active consideration by the government. We've obviously been seeking to find the capacity to be able to move that project forward, recognizing that the current space they're in, being a former school, is not ideal for the complex care that is being provided there. But there has been no announcement made yet with respect to Runnymede hospital.

Mrs. Witmer: So at the current time there has been no progress whatsoever. It's still hoping.

Hon. Mr. Smitherman: No, I think there's been substantial progress. I just said that there hasn't been an announcement.

Mrs. Witmer: Right. Is there money allocated in this estimate for Runnymede?

Hon. Mr. Smitherman: We'll be in a position to be able to make an announcement about Runnymede when we make an announcement about it.

Mrs. Witmer: Going back to Woodstock, is there any money in this estimate for Woodstock hospital, for any part of the project?

Hon. Mr. Smitherman: I believe that Woodstock has had all of the resources already provided with respect to their planning and design work. Of course, that is in good shape, so my expectation would be no, for this fiscal year.

Mrs. Witmer: So there's no additional money for Woodstock—

Hon. Mr. Smitherman: None is required. Obviously, they're in a phasing for development that doesn't include this year, and as I mentioned already, the planning and design work has been completed and fully paid for.

Mrs. Witmer: What about Cambridge, which has been forced to use their own money first? Is there any money in here for Cambridge hospital?

Hon. Mr. Smitherman: Yes. We provided money to—it's not entirely accurate to say that they've been forced to use their own money first. What we worked on with them was a solution that would provide resources over two fiscal years that would augment the local share that they had on hand. Those resources are being provided over two fiscal years, and I'll just check whether it was 2005-06 and 2006-07 or whether it was—I believe it was 2005-06 and 2006-07, a total of $8 million or $9 million from the government of Ontario. Some of that has already been provided and some will be provided in this fiscal year.

Mrs. Witmer: Can we get that answer, then?

Mr. Sapsford: It's part of your first question, yes, the list of projects—

Mrs. Witmer: So it will all be there.

You've mentioned the new nursing positions. In the handout, you indicated that in terms of the new graduate initiative, the number had changed from 1,000 to 1,522. Are those permanent full-time positions?

Hon. Mr. Smitherman: No. Those are permanent recurring positions, however, so we count them one time, not on an every-year basis. It's the same explanation that I offered at estimates last year. The differential here is that the number of dollars that we've had available have been used well by Ontario's hospitals and long-term-care homes and have achieved a higher number of new nursing grads who have been able to benefit from the initiative. So each and every year in the province of Ontario that number of positions can reasonably be expected, and if we look to 2007-08, in the column towards the bottom there, you can see that it's our expectation that we will enhance that again in the next fiscal year.

Mrs. Witmer: How long are those positions?

Hon. Mr. Smitherman: They range from three to six months.

Mrs. Witmer: You had made an announcement earlier this year that every new grad would be guaranteed a position. Is there funding in—

Hon. Mr. Smitherman: I announced that for next year, of course. That would be in the next fiscal year. The other thing that we should note is that the Ontario health care system has quite a lot of annual capacity through attrition for currently filled full-time positions to be replaced with new grads, so one would anticipate that in a system where there are tens of thousands of nurses, the system itself would have the capacity to provide employment for a very large number of new nursing grads. This work is being led by Mr. Tom Closson, with a task force that includes a very wide spectrum of individuals, and we could anticipate that more information will be forthcoming as we move towards graduation next spring.

Mrs. Witmer: So there has been no money allocated in this year's estimate to achieve the objective of full-time positions for those—

Hon. Mr. Smitherman: Well, as the objective comes into place in the next fiscal year, it will be more appropriate that we have resources in that fiscal year as required. Whatever resources might be required for the management or for the development of the task force, the deputy could indicate to you from where those minor allocations would be required. But this is an initiative for spring of 2007, and accordingly, any funds related to that would be in that fiscal year's estimates.

Mrs. Witmer: Where is the money in here for the 8,000 nurses that you had promised to hire by 2007?

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Hon. Mr. Smitherman: The sheet indicates, of course, that across the breadth of funding increase that our ministry has had the privilege to advance, to date, through our initiatives 4,299 positions have been funded and filled, with further funding available in a wide variety of ways that will bring another 2,513 positions to the fore. So it's very, very easy to see where the money is. It's been divided out for you.

I'd just give you one example to tease that information out. If you look on the list where we've added 69 nurses this year for diabetes, this relates very directly to a funding announcement that we made to establish 69 diabetes clinics in a wide variety of community health centres. So each of these has a very, very distinct story line and distinct funding associated with it. We'd be very happy to work through those on a case-by-case basis.

Another one I'll bring to your attention: family health teams. We can see that to date 48 new nurses have been hired in family health teams. If we go down to the next page, to the lower part, under 2006-07, 204 nurses have been approved for hiring in family health teams, which means that the funding is allocated and those positions

are currently being filled. If we foreshadow to 2007-08, based on projections of the amount that we will allocate to family health teams, you can see that a further 348 nurses would be anticipated in the service related to family health teams.

All of these numbers totalling down, with more progress to be made through an additional year and a half—you still note that these totals are coming in towards about 6,800, representing very, very good progress indeed towards the commitment that we've made with respect to new nurses in the province of Ontario.

Further information is available, as an example, from the College of Nurses, which has demonstrated quite significant increases in nursing employment in the province of Ontario.

Mrs. Witmer: I guess the numbers look different if you subtract the new-graduate initiative, because you're really only dealing with someone who is in a position for three to six months. It's certainly not permanent full-time. So if you take a look at those numbers, you're not close to hiring those 8,000 nurses that you had indicated you would.

Hon. Mr. Smitherman: I would argue that if you wish to—firstly, we had this conversation at estimates last year, of course, but we can go through it all again. I suppose it's easy to wave those away, but the reality is that each and every year in Ontario, on a recurring basis—we've counted only once—many new nurses are given the opportunity of employment as nurses on the front lines of health care. Like I said before, we'll be working very, very vigorously towards our commitments we've spoken about already in the spring to enhance these numbers. We're very, very satisfied with the progress we're making in enhancing nursing employment in the province. We're very pleased to see that nursing has not gone through peaks and valleys, as has been the tradition across nursing over the course of the last decade or so, but has been on a very, very steady and continual rise, and we would expect to continue to increase the number of nursing positions that we're funding in Ontario.

Mrs. Witmer: I guess I would just correct for the record: Nursing has not gone through peaks and valleys in the last decade. Since 1998 the number of nurses in the province of Ontario has actually increased. In fact, we were able to create 12,000 new positions. So the numbers have been going up in recent years, ever since we had a committee in place that made recommendations to improve the quality of life for nurses. I think that's really quite important to consider.

Hon. Mr. Smitherman: For that statement to have worked, all you had to do was pretend that you weren't the government for three years. I mean, you said "from 1998." That kind of makes my point for me. Do you want me to rehash the circumstances through there? Do you want to tell me that there weren't peaks and valleys with respect to your government's record with respect to nursing employment?

Mrs. Witmer: I'm saying, since 1998 the numbers have been headed in the direction of increased positions.

Hon. Mr. Smitherman: It's a shame about those early three years, then.

Mrs. Witmer: The shame would be in these new-graduate initiatives, where you're trying to claim a three- to six-month position as a new nursing position, which it certainly isn't. You could easily deduct 1,522 positions from your number here, if you wanted to be—

Hon. Mr. Smitherman: Or pro-rate it.

Mrs. Witmer: —absolutely accurate.

Hon. Mr. Smitherman: I've just got some data: From 1995 to 1998, according to the College of Nurses of Ontario's membership survey, there were 6,279 fewer nurses in Ontario hospitals. I'll get in a second the information that just came out from the College of Nurses with respect to the improvement, I believe, from 2004 till 2005, not just an improvement in terms of the number of nurses working, but in fact a fairly significant improvement in the percentage of nurses who were working full-time. For this year, the first time in nine years, the average age of nurses in the province of Ontario has not gone up, which is a very good sign that we're having the capacity of bringing new nursing grads into the nursing workforce. We've had a significant improvement in the percentage of nurses who are working in only one environment, eliminating some of that pattern from before, where they had to cobble together an existence from a variety of places. So on the issue of nursing, of course, this is a very, very challenging one. We've all got a record. We're very, very proud of our record.

In the data that the College of Nurses has prepared for us, from 2004 to 2005 they indicated 3,470 additional nurses—RNs and RPNs—working in the province. You can see from that that if we were to go with their numbers rather than the ones I have presented, of course our numbers would be even higher.

So I do say to the honourable member, who knows well that the circumstances are such that there are a lot of different data out there with respect to nursing, there has not been, even through the good work of the Nursing Secretariat, the capacity to have one-stop shopping on data. It's always been necessary with respect to nursing to cobble that information together. I'm very proud to say that through our HealthForceOntario initiative, by putting additional resources in there, we're creating a much better capacity to have good-quality and available data, but based on the numbers that we've been able to present to date, I think there's an indication that if we worked off the numbers provided by the College of Nurses of Ontario, my numbers would be lower than actual.

Of course, we can have a discussion all we want about one of the numbers that's there, but in fairness to the numbers that we have presented, the College of Nurses says that our numbers are actually artificially low.

Mrs. Witmer: I would just make one point. The point I was making was this: You indicated that there had been peaks and valleys. I guess I wanted to remind you and put on the record the fact that since 1998 the numbers had increased, and that was the only point. I wasn't disputing the fact that there were not additional nursing

positions. I was simply saying that that extended for a longer period of time than your government had been in office. In fact, I would remind you that you were the government that spent $91 million to fire 757 nurses.

Hon. Mr. Smitherman: I'd be very happy to give the honourable member an update on that. I believe this is coming forward soon in an answer to a freedom-of-information request. It is true that, through numbers that we'd received, I did make an estimate of the number of nurses who were going to be laid off. I'm very happy to be wrong. The reality is that we got information subsequent to that which shows that the number of nurses who were actually laid off through any of those processes numbered something less than 150, and 70 of those were casual nurses. So we're really, really proud of the efforts that Ontario's hospitals made subsequent to that discussion to continue the employment of nurses. So the stated number, I could say, thankfully, has been lessened by about 400% or 500%. In other words, the total number of nurses laid off was 132, consisting of 36 full-time, 26 part-time and 70 casual.

Mrs. Witmer: We can be thankful that the hospital CEOs, in their wisdom, kept those nurses within their operations.

Hon. Mr. Smitherman: I will just tell the honourable member that we didn't make the number up. The number that we were operating off and that I put in the public domain was an estimate that had been supplied to us by those very same hospitals. But we agree that the boards have worked very, very vigorously with their professional staffs in a fashion that recognizes what we all know to be true, which is that nurses are the heart and soul of health care and are so fundamental to a good, performing health care system.

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Mrs. Witmer: Going back to the new nurses who are going to get positions—

The Chair: Final question.

Mrs. Witmer: Okay. You indicated in your press release that there were going to be 4,000 graduates. When are you saying that that new program is going to be implemented, and what is going to be the timeline? If I graduate next May or June and I'm one of 4,000 people, am I guaranteed this job, this full-time employment?

Hon. Mr. Smitherman: Yes. That is the thrust of the policy. As I've already mentioned to you, obviously that is a very, very complex piece of policy to see in place. I know you were critical, on the day we announced it, that every "t" hadn't been crossed and every "i" hadn't been dotted, but our fundamental view, our operating viewpoint, is quite different from the one I suppose you might have preferred. We know that the primary responsibility for the relationship with nurses is their employer. In this case, of course, and in almost every instance, that's someone other than the government of Ontario, with a few modest exceptions. Accordingly, what we think is prudent is that we've asked Tom Closson—a very distinguished person in health care, with a breadth of expertise that is, I think, almost untouched by any other—to bring together a task force of people and to help give appropriate guidance to the best way to bring that policy forward.

As I've mentioned, attrition is an important part of the opportunity that is provided. If we look at the University Health Network, the largest hospital that we have in the province of Ontario, they have an attrition rate of something like 8% or 9% on their nursing workforce. That numbers thousands of nurses in total. Accordingly, it represents just one example of the kind of institution that can play a really, really important role in helping us fulfill a commitment to nurses which we think is long overdue.

I'll say one other thing as well. I believe that the work that will be done by this task force will help to address something that I think has been a long-standing problem in our health care system. As we make a big investment in energy, as we seek to enhance the quality of our faculties, as we pay for more seats at our nursing schools, we obviously want to do a better job for those nurses to give them a more solid link to the kind of stable employment they wish for. We also know, of course, that that's beneficial to patients.

My boss, the Premier, was recently in Windsor and toured a hospital with my colleague Sandra Pupatello. He was very pleased on that shift—just one shift at a Windsor hospital—to meet eight nurses who, not very long prior, had been working across the river in Detroit and, as a result of the initiatives that we've been involved in to enhance the percentage of nurses working full-time, had found stable, full-time employment in Windsor hospitals. I'm not saying that we've got the thing licked, not by any stretch, but we do feel like we're on a very good path of progress there.

The Chair: Thank you very much, Mrs. Witmer. I'd now like to recognize Ms. Martel.

Ms. Shelley Martel (Nickel Belt): Thank you, Mr. Chair. I will proceed to questions. As well, I want to thank the minister for being here today, making himself available. Deputy and other staff who are here from the ministry to help answer questions: Thank you for your participation in this process.

I wasn't going to begin with nurses, but I want to follow up on some of the questions that have been raised. The first has to do with the freedom-of-information request—because, unless there's another one, that would be mine—for information about nurses. Where I want to start is with the information that you gave the committee about 132 layoffs. I'm going to assume that was for fiscal 2005-06. Is that correct?

Mr. Sapsford: Mm-hmm.

Ms. Martel: So the 757 layoffs that you talked about in January 2005 actually related to fiscal year 2004-05, if I am correct. Is there someone who's going to—

Hon. Mr. Smitherman: You can ask questions of me, and we'll figure out who answers them.

The announcement was made at the time. This was at the initiation of a process. You know very well that the length of layoff provisions associated with the nursing

contract would not have resulted in any of that employment occurring in a 2004-05 context. So I believe that's the answer.

The conditions of the ONA contract: If you look at when I said that and apply the layoff provisions that are associated with an ONA contract, you'd most certainly be into the fiscal year that the order paper question or the FOI request got at.

Ms. Martel: But there would have been a second series with respect to the process that hospitals were going through for 2005-06 as well, because there were also layoffs announced for that period of time. I am making a distinction because I thought there was a distinction between the layoffs you announced that were for a period that was almost ending and then a second set of numbers for layoffs that would have occurred in 2005-06, when the ministry then started actually reporting on layoffs.

Hon. Mr. Smitherman: I didn't make any announcement about layoffs. I said that—

Ms. Martel: I didn't say you did.

Hon. Mr. Smitherman: Just hear me out. At the point that I put any number in the public domain, that was based on analyses that hospitals had provided us as we were seeking to get them to get their books in accord. The numbers which we provided to you, that I provided to committee and that are coming in terms of the answer to the FOI request are the numbers that are, if you will, the outcome of the very, very same process. The process has taken place over a period of time because of those layoff provisions that I've spoken about as an example. We started with an indication of what might occur and we have answered on point to the question that was asked about the status of nurses laid off in the 2005-06 period. That would be the information we have to date. If there are further implications related to that, then that would be forthcoming in additional reporting periods.

Ms. Martel: From what you're saying, of the numbers that you're going to give me and that you've given to the committee today, 132 would be all the layoffs that have come as a result of your telling hospitals that they had to balance their budgets as of the end of fiscal 2006. Is that correct?

Hon. Mr. Smitherman: Yes.

Ms. Martel: So even though in 2004-05 there was no reporting, that requirement only started April 1. None of those layoff provisions would have kicked in until a period after the reporting actually commenced?

Hon. Mr. Smitherman: That's right. Just to go back to the data, just on the 2004-05 question: The College of Nurses of Ontario reported a 3,470 net increase in nursing during that 2004-05 period—just for the sake of reference, as you brought those numbers into play.

Ms. Martel: I understand that, but the problem was that even during that period, 2004-05, the layoffs were being announced, whether by you—there were also hospitals doing that on their own.

Hon. Mr. Smitherman: There were also a lot of hospitals that made big announcements about layoffs where no layoff occurred. Lakeridge Health would be a really, really prime example of that, where they actually said something like—I think the number was 70. I'm going by memory here. In actuality, those never took place.

Ms. Martel: I was thinking more about the Sault Area Hospital, where some 30 were announced, or Bluewater in Sarnia, where a number were announced—not just nurses; a whole range of staff, where there had been a peer review as well.

Hon. Mr. Smitherman: The Bluewater one had been more related, I believe, to security personnel and stuff like that. Maybe there was something related to the operating room.

Those are the numbers as I've explained them.

Ms. Martel: Let me go back to the same page and get confirmation again about the numbers with respect to the new-graduate initiative, because we had this conversation in the last set of estimates. Of the 1,522 that are mentioned, are you telling us then that none would represent individuals who had been bridged into a full-time position?

Hon. Mr. Smitherman: I'm telling you that these are the numbers for the new-graduate initiative positions that have been created. Subsequent to that, some of those may have bridged into new positions. You'll note at the very top line in the hospital sector, 1202, that if there are people who were bridged into that, we certainly haven't double-counted them. The $50 million that we put very early on into nursing to create full-time employment—those are the only numbers that we've counted here.

It may in fact be, and that would seem to back it up, that the College of Nurses' numbers were probably undercounting our numbers. There's no doubt whatsoever that many of those that entered a hospital or long-term-care environment related to the new nursing grad initiative have subsequently received the opportunity to be bridged into full-time employment. That is likely dealt with in attrition rates. We don't have those numbers, but we certainly haven't double-counted people.

Ms. Martel: Can I have copies of the positions that were created for 2004-05 in both long-term-care homes and hospitals, the numbers that were allocated with the funding that was allocated? I don't have that information for 2005-06 and I'd like to know if it is available.

1700

Hon. Mr. Smitherman: I believe you only have that information for the earlier year because the funding was initiated in that year and has been maintained subsequently, so it's not like it was altered in subsequent years. It's funding that was in place and, as you can see by the numbers on the hospital at 1202, that has remained in place. The long-term-care number has moved only because we've gotten the results of more comprehensive surveying back that has allowed us to confirm the number at 682 rather than the 375 that we had estimated.

Ms. Martel: Let me back up. I'm looking at numbers for the new graduate nursing positions.

Hon. Mr. Smitherman: Oh, okay. What we found—I'm sorry.

Ms. Martel: In 2004-05 I was given a list of both the long-term-care homes and the hospitals that received funding in that fiscal year for those positions and the number of positions. What I'm requesting is information for 2005-06—

Hon. Mr. Smitherman: Sure.

Ms. Martel: —if it's available, both the long-term-care homes that received money and the hospitals, because I'm assuming it doesn't duplicate from one year to another.

Hon. Mr. Smitherman: Right.

Ms. Martel: Different requests are made.

Hon. Mr. Smitherman: I misunderstood your question. Yes, we'll get that for you.

Ms. Martel: Now you are into the third round of funding for this initiative this year?

Hon. Mr. Smitherman: The new-graduate initiative?

Ms. Martel: Yes. Am I correct about that?

Hon. Mr. Smitherman: I'm not sure which fiscal we're into. I think we're just into the second fiscal. I'll get clarification on that for you.

Ms. Martel: Okay. I wondered if you were in phase 3, so had applications gone out yet for phase 3 or not, for the same program? So if you can clarify that, that would be good.

Hon. Mr. Smitherman: Okay.

Ms. Martel: I also want to go back to long-term-care numbers because I hadn't received an update even though I had had an FOI in from March asking for the balance of the numbers. With respect to the long-term-care numbers, I would appreciate receiving information regarding where those positions then were created in the long-term-care homes. This is for the money; not for new graduates but the money that was allocated for homes through various long-term-care announcements.

Hon. Mr. Smitherman: We'll provide that.

Ms. Martel: That would be great.

I want to ask some other general questions about nursing. I've asked for the information regarding 2005-06 of the new-graduate initiative, and I would like to get the same sort of information for the late career and mentoring initiative. I understand that phase 3 of that is underway. I don't think I have any information at this time with respect to what hospitals would have received funding and how much. If you have two fiscal years where you have that information already in existence, I would appreciate getting the information about that, and also clarification that the phase 3 application is underway.

Hon. Mr. Smitherman: Yup; done.

Ms. Martel: That would be great. I don't know if the nursing secretariat has this information. I think in the last set of estimates it was stated to me that the information was actually with the Ministry of Colleges and Universities, but I'll just check this again. I would wonder about information regarding both degree nursing enrolment data and also degree nursing graduate data, so both enrolment numbers and graduate numbers. In the first case, for degree nursing enrolment data for 2004-05, I'm not sure if the nursing secretariat is represented here in that—

Hon. Mr. Smitherman: Whatever of that is available, we'll obviously be very happy to provide it.

Ms. Martel: It can't be provided today?

Hon. Mr. Smitherman: I wouldn't think so.

Ms. Martel: Okay. Then as well, the 2003-04 degree nursing graduate data, the distinction between the two. That would be very useful.

I want to ask as well about nurse practitioners. I know you've given us information with respect to nursing positions.

Family health teams: I'm going to assume that the 48 that are listed there are for registered nurses.

Hon. Mr. Smitherman: That's right.

Ms. Martel: Do you have some information about nurse practitioners and how many have been hired to date, and can I get that now?

Hon. Mr. Smitherman: Yes. We should be able to provide you as well how many have been confirmed for funding that have not yet been hired. In the same way that we've been able to do on this chart, we can provide that for you.

I could also just give you one small update on nurse practitioners that might be helpful. As you probably know, it was our commitment by 2007 to double the number of nurse practitioner seats to 150. That will be achieved this September. There will be a necessity on the ministry to find a little bit of resource from within because they've achieved that sooner. So it won't be totally reflected in our estimates. We will come up with another few million dollars to support that, but the schools have been successful at achieving the increase in the number of NP seats. It will be at 150 this fall rather than in the fall of 2007.

Ms. Martel: Do you know how many additional dollars, because you said that will have to be found from within, what the total allocation would be for that to move it up one year?

Hon. Mr. Smitherman: We can get that for you.

Ms. Martel: Also, could you give me the breakdown between those programs that are actually offering the nurse practitioner program, because I know there are a number of them, or that have been allocated the additional seats?

Hon. Mr. Smitherman: Sure.

Ms. Martel: He's nodding. Thank you, Deputy.

Let me ask, then, one more thing with respect to hepatitis C that I see here. These are new nursing positions, full-time equivalents, that foreshadowed, and hepatitis C is listed there. What is that in reference to?

Hon. Mr. Smitherman: We had a meeting yesterday with the hepatitis C task force. They've been giving advice to the government around the initiatives that we need to undertake to do a better job of supporting people with hepatitis C. There are significant issues, as an example, around compliance when people are on the treatment. There is a variety of positions in the public health care system right now where nursing is being

funded by pharmaceutical companies that are also the providers of the drug product.

This would be the first tranche, and there are approximately 20 of them. This would be to take back the responsibility on the public for the provision of those nursing roles. We will have an allocation in 2006-07 to support the infrastructure, the training and the information technology infrastructure that will, in the next year, support nurses going into the field, the first tranche of which is noted here, at least to replace the funding source for those who are being provided currently by the pharmaceutical industry.

Ms. Martel: That funding then will come from which source? There are two sources of money in Ontario right now. You've got care, not cash, funding that's essentially federal, but you've got also a balance of funding, about $111 million, I gather, that is in place from money that was allocated by the former government originally to hep C victims. Which pot—

Hon. Mr. Smitherman: It might be argued that it could come from the former. It certainly does not come from the latter. So the fund that is there that was established for compensation continues to be a fund that has about 60 applications a month, so it's an active fund. This would be an investment on the part of the government of Ontario and it would be part and parcel of that analysis that we are obligated to provide. I think the next update on that is at the beginning of 2007 that demonstrates that the dollars being sent by the federal government are being spent appropriately.

You and I will know, through a variety of vigorous exchanges in the Legislature and elsewhere, that there are really two different interpretations of the resource allocation of federal dollars. We have completely demonstrated and fulfilled that resources sent to Ontario for the provision of care for those with hepatitis C have been spent in those fashions. This is one more example of our work to enhance and to develop a more integrated and proactive strategy for assisting people with hepatitis C in Ontario, and we have a very active task force on that that's chaired by John Playter. As I mentioned a second ago, I had the privilege to meet with them yesterday morning.

Ms. Martel: We do have a difference of opinion about the care, not cash funding, but we don't have to get into that right now.

My concern remains with respect to the money that was left over from the former government when they went ahead and started to compensate. I gather there's about $111 million left in that pot. Would that be correct?

Hon. Mr. Smitherman: We'll get you that number. The number, as I said, is a fluid one because there continue to be applications on that fund, but there is no doubt whatsoever that there are resources there that are available for allocation for those purposes.

Ms. Martel: Just so I have confirmation, the 20 positions would come from what source again?

Hon. Mr. Smitherman: From the source of the general revenues of the province of Ontario.

Ms. Martel: In terms of the money, it would be useful for me to know—I can't speak for anybody else, but you share it with the whole committee—from the funding that was set up by the Conservatives, what is left in that particular pot of money which you said you would—

Hon. Mr. Smitherman: It may very well be the number you're quoting, but I don't want to put the wrong number in the public record. We'll provide that to you. I believe that on orders of magnitude, we're pretty much on the same page.

1710

Ms. Martel: Then I've been mistaken about something, because I assumed that you established a task force to look at how to spend the balance of that pot of money, not that that money was being drawn down at this point in time.

Hon. Mr. Smitherman: No, it's not accurate. Obviously, that's one of the issues where they're going to have some advice to offer. I established a task force because I hadn't been convinced that the strategic work that had been on the issue of hepatitis C had appropriately involved all of those, including some who were most affected. The previous government's initiative on the development of a strategic plan around hepatitis C left out all of those who are street-involved, as an example. I think you and I both know that this is a community with risk prevalence related to hepatitis C. Accordingly, we felt that it was appropriate to ask a group of people reflective of the diversity of the population experiencing the challenge with hepatitis C to be involved, and that's what they're doing. They've been giving us advice on communications campaigns. You and I had a chance to engage on that recently. They've provided us with advice with respect to this nursing initiative. They're doing a wide variety of other research to try to assist and give guidance to the government.

We're modelling this very much after the initiatives of HIV, of the AIDS Bureau, in the ministry. We've created a distinct secretariat related to hepatitis C, which is up and running and supporting the work of the task force. So I think it is appropriate to assume that the task force will bring us recommendations around other resource issues, but for now, to be very clear, their focus has been on communications, on the nursing initiative and on the efforts to get the secretariat up and running.

Ms. Martel: With respect to the 60 applicants a month that you reference, which would have been essentially the federal money?

Hon. Mr. Smitherman: No, 60 applicants a month for the remaining amount from the fund that was established by the Conservatives. The issue is that the federal—maybe I shouldn't get into that.

I'll just say this one point. A lot of people try to make it seem like the federal fund is a federal fund, but the reality is that's a court-ordered fund that all jurisdictions were required to pay into, and it's not so easy as a policy or political decision in terms of what alteration might be made to it. It has been an active conversation from time

to time among first ministers. Just that one point of clarification.

Ms. Martel: The 60 applicants are essentially getting compensation then, as those come through?

Hon. Mr. Smitherman: There's a committee that makes those determinations. I think it operates as an adjunct of the Health Services Appeal and Review Board. It's supported there administratively.

I don't know whether we offer statistics on the success rate related to applications. We could look into that, or perhaps the deputy has more information. I would say no. I'm sure that they're not all being—I rather suspect that not everyone who applies is a successful applicant.

Ms. Martel: I would appreciate it, Deputy, if it is possible to get the numbers from the point in time where the funds started to be drawn down to whatever the most recent statistics are.

Mr. Sapsford: There are very specific criteria of qualification and it's adjudicated outside the ministry, but I'll see what information is available.

Ms. Martel: If you could get both the number of applicants and the number of successful applicants, that would be great.

I want to start some questions with respect to long-term care because I see, Minister, in your speech from today that you talk about long-term-care legislation being introduced soon. This has gone on for quite some long time in terms of actually getting some legislation. I go back to the major announcement that you made on May 11 when you released Ms. Smith's working paper. You had anticipated that we would have legislation in the fall of 2004. That was reiterated the next two days, May 12 and May 13, that there was going to be a major piece of legislation on long-term care in the fall. That was repeated on August 27 in a Toronto Star article that was done by Rob Ferguson. You said upcoming legislation would make family and resident councils mandatory. It looked like it was going to be the fall, and then it changed to the spring of 2005. In May 2005, it changed to the fall of 2005. We're here now looking at, we hope, legislation soon.

I noticed that in the speech itself it says "before the end of this legislative session," and you said "soon." I'm not sure which one it's going to be. Do we expect introduction of this legislation before we rise, or is this going to be delayed?

Hon. Mr. Smitherman: Maybe; maybe not. This is a very accurate reflection of the current state of thinking. We've been working on the bill vigorously. Obviously, it has taken longer than we might have anticipated. We've moved forward in a variety of ways. The legislation is one element of an overall strategy to address the necessity of a really well-functioning long-term-care system. It really is a matter now for us of whether this bill comes in just before we rise for the summer or whether it comes in just after we come back in the fall, but it certainly is a bill that will be before the House in 2006. We'll look forward to a vigorous debate related to it.

Ms. Martel: Might I ask what the delay has been focused around? I ask that for two reasons. One, it was my assumption that when Ms. Smith did her work, much of the legislation would be based on the work that she had done. I think that was the public implication as well in statements that were made about the release of that document. Secondly, the ministry put out as well a consultation paper, a working document that many people responded to by the end of 2004, yet we are still here in June 2006. What has been the reason for the delay about having something before the Legislature?

Hon. Mr. Smitherman: In a word, prudence, which is the necessity of getting an act that is very likely to be the foundation for the long-term-care sector. If we look at other acts, they very often are in place, as you would well know, for 20, 30, 40 years; in some cases, even longer. That's the predominant thing there. It's a very complex bit of work.

I'd say two things. Obviously, it's not the only thing that we've doing at the Ministry of Health, with a very active and busy legislative agenda, but it really is about prudence. We did consult very broadly and have made ourselves available to work with a wide variety of groups. Some elements of the package have required us to do a very substantial amount of due diligence in order to ensure that we get it right. That really is the reason that this has taken longer to get into the House than I had predicted on several earlier occasions.

Ms. Martel: Can I ask about the consultation with respect to the bill itself? I'd like to raise this question about consultation with respect to the provisions of the bill itself. Earlier, probably in February, there was a press release that went out from Chartwell Seniors Housing Real Estate Investment Trust. A copy was sent to me, and they were commenting on the proposed new long-term-care legislation being considered. They said, "Under the proposed new legislation, the provincial government is considering limiting the term of long-term-care home licences." The release went on to describe some of the concerns that they had. They certainly left the sense that they had seen portions of the legislation.

In contrast to that, I know that there have been a number of unions who represent front-line workers who have asked the ministry to see some of the legislation before it's actually brought forward, primarily because they represent workers who are in the sector. You had a letter sent to you on April 24 by ONA president Linda Haslam-Stroud asking for input, asking if they could see the draft legislation prior to its finalization to table any problems that might be in the draft, as well as providing any of their suggestions on how to overcome them. The same type of request was made by SEIU on February 27 in an e-mail that they sent to Ken Chan, which was responded to by Ms. Smith, saying, "Well, you had your consultation when I did my work around the draft document, and you had your consultation at the end of 2004 when you responded to our consultation paper. That's the end of the consultation." We also had the very same thing from Donna Rubin, because we checked with

her to see if they had been involved in any way, shape or form and had seen some of the draft legislation.

My concern is that there was certainly an indication from this release that somehow Chartwell had seen some concrete details about the legislation at a time when others were asking for the same thing, especially those who are on the front lines. So can I ask, who has seen the draft legislation?

1720

Hon. Mr. Smitherman: Nobody. You've drawn your own inference from that. It's no secret that one of the elements of our legislation is related to licensing, but there has been no sharing of drafts or any proposed language with anyone. The biggest reason for it is very obvious by the nature of the company that's asking the question.

So no, this has not been shared with anyone. I have very regular meetings, particularly at present, with those unions you've spoken about, but we have not—on this subject particularly—shown the draft legislation, nor the language, to anybody. It's not our intention to do so. It would be our intention to engage in a round of consultation only once we've had the opportunity to introduce the bill. That's the strategy we've been deploying on health bills. You could see that on Bill 102. That's why we believe so fundamentally in using the committee process as the opportunity to alter the bill in whatever fashion might be appropriate after we've had the chance to speak with people who have seen it.

So Chartwell—you make an inference there about knowledge. I would say to you categorically that this has not been shared with anybody.

Ms. Martel: I think that's the only inference you could draw if you read it. That's why I raised the question.

Hon. Mr. Smitherman: I don't think so. The idea of a licensing regime is no surprise to anybody. That's been out there in the public domain, and of course in any instance the unknown is more likely to fuel correspondence like this than the known. They know there's a discussion about terms with respect to licensing. That's the end of their knowledge base. Anything that has been done subsequent to that is just by inference.

Ms. Martel: In terms of the letter that came from ONA, is someone going to be responding to them to say that all consultation is going to occur after the bill has been—

Hon. Mr. Smitherman: I reasonably suspect that through all of the personal engagement that I have with Linda Haslam-Stroud—I've responded to her letter in person, but yes, of course, in due course we seek to respond to all of our correspondence. With the deputy's good efforts, we're getting a lot better. This might be one of those where the response hasn't been timely, but yes, of course—but this is now a matter of principle in terms of the way we've operated as a government. It's important from our ministry standpoint that we get our legislation into the House and give everyone an opportunity at the same time to review it, and we make sure that we provide lots of opportunity for response to it and make alterations in accordance with what we hear.

The Chair: One minute, Ms. Martel.

Ms. Martel: Actually, then, I'd pass, because the next round has to do with funding for long-term care, so I'd like to do that as a block.

The Chair: Thank you very much, Ms. Martel.

Minister, you have about a half an hour, if you so choose, to respond to any of the opening segments. It's your time. When you're done, we will begin rotation with questions, so we're in your hands.

Hon. Mr. Smitherman: Sure. I'd like to take the opportunity to speak about some of the subjects that have been raised so far.

We had a good chance at the beginning to speak about capital projects, and I do think that it's very important when we discuss capital in the province of Ontario that we understand that the investments we are making through the work of the Ministry of Public Infrastructure Renewal create the capacity where our government will make greater investment in health care infrastructure than five previous governments combined. Minister Caplan's efforts are seeing a renewal of the health care infrastructure across the breadth of the province.

If we look at it in the context of Woodstock, to follow up on a question that the member from Kitchener–Waterloo asked, we would see that approximately $12 million would be spent on equipment at Woodstock, so you could see there that a net swing for Woodstock of about $18 million seems like the reality.

If we look at the response that's occurred—for instance, I believe the Montfort Hospital is, if not in the riding of my friend from Ottawa, then obviously of tremendous service to many of his constituents. The projected net benefit to the local community of the Montfort Hospital currently being doubled in size is about $26 million.

I think you see something of our instinct in the initiative that I undertook quite some time ago, particularly with respect to the challenging circumstances that hospitals in Thunder Bay and Sudbury were facing. Those hospitals are especially large in the grand scheme of things because they're playing a role well beyond the local population that they serve, playing a much broader regional role, as regional cancer centres and trauma centres as an example. We have felt for some time that it was necessary to revisit the amount of resources that the province of Ontario was prepared to put in.

We're not interested in a circumstance where we build hospitals in Ontario where local communities are so encumbered that they're not able to raise the local share. This then puts an even greater risk in play. It is the risk that hospitals would seek other forms of financing to, if you will, plug gaps in their local share. The difficulty we have with that is a very obvious one: There's no revenue stream particularly to support that, and we're not interested in a circumstance where we see operating dollars put at risk in order to service debt. That's why we felt it was appropriate to go back to cabinet and to bring

forward a policy which enhances the government's participation in overall hospital capital funding.

At the same time, like I said before, when we did discuss this policy development with our partners at the Ontario Hospital Association, the consensus was very clear and very strong that it was very helpful indeed for hospitals to still have a portion of the overall hospital costs that they had to raise from local share. This still gives them all of the potential for naming rights, which we know have been a very successful method of fundraising, but at the same time getting them more into areas like equipment that have the benefits that I spoke about before but I think are worth repeating.

Firstly, more bite-sized chunks: After all, hospitals enjoy support from thousands and thousands of people in communities, and by being able to make available funding opportunities that are smaller in the grand scheme of things, they have a much enhanced marketing capacity. But it's been important also to be able to just give more flexibility to local communities on the basis that we were speaking about before, which is the capacity to bring forward new equipment on a phased basis consistent with their local capacity. I think this is one of the primary benefits associated with the initiatives we've been involved in.

With respect to nursing and nursing numbers, I know that we had an excellent opportunity to discuss those things, and a lot of new numbers were there, but I do want to say that while much has been said about the issue of nursing layoffs, in a very real sense much more has been said than is appropriate in the circumstance if you look at some numbers.

I'm proud to be part of a government where, each and every year that we've been in life as a government, we've increased the number of nurses who are working in the province of Ontario. We've dramatically enhanced the health care funding that has made that possible. Our results stand there for people to consider them, and they stand in very stark contrast to two patterns that occurred under the two other parties that are represented here at this committee. I put on the record already the implication of the Conservative period from 1995-98, when we know that the College of Nurses indicated that 6,279 fewer nurses were working. That was 6,279 hula hoops sent to the dustbin at that time. But we look also to the days when the New Democratic Party was in government and our colleague was a cabinet minister in that government. The information provided by CIHI on the supply and distribution of nurses in Canada indicated that 2,944 fewer nurses were working in Ontario health care at the end of Ms. Martel's period in government than at the beginning.

As I said, while we have more work to do, of course, to fulfill the commitment of 8,000 that we've made to the people of Ontario, I'm able to offer to this committee a very strong demonstration not just of our commitment and not just of our words, but of the results that we've been able to produce. We're very grateful for the quality of the nursing workforce that we have in the province and for the results that they have been able to achieve.

On the issue of the commitment that we've made with respect to new nursing grads being offered full-time employment next spring, we really feel like this is a commitment that's long overdue.

1730

We do have challenges, I must say, in the government of Ontario in the history of the Ministry of Health with respect to health human resources. I think that sometimes, because we don't play the direct employer role, it's a frustrating circumstance for us because people look to the government as the be-all and end-all on initiatives related to health human resources. We are going to step up to the plate and assert our leadership in an appropriate way, and we're really aided in our capacity to do that by the intense focus we've placed on health human resources.

Yesterday, as Mrs. Witmer knows—we were so glad she was able to attend—we had a very enthusiastic group of international medical graduates in Toronto; of course they're working in a wide variety of areas. If you look at the work we've done on that file in the days since we've come to life as a government, 86 foreign-trained doctors have already fully completed their training and are out there in service to Ontario, 287 are currently in the training system and a further 217 are entering that through the course of the summer and this fall.

These are very pronounced improvements, but the point I wanted to make is that people should expect more of us on this front. We very recently became the first jurisdiction in Canada that has an assistant deputy minister of health human resources, and that's Dr. Joshua Tepper. I hope you might ask some questions that would allow you to work with him.

What we figure is that over a period of time, the Ministry of Health has sometimes been a little too focused on the day-to-day, a little bit at the expense of the longer term. It is rather easy to see, in an environment that deals with health care and the all the intensity there, and with the scale of our ministry, that if you're not careful, it's very hard to have the time where you're looking a little more to the longer term.

We're working vigorously and, as I mentioned before, the deputy has been bringing forward a transformation of the ministry that gets us beyond siloed thinking to the point where we're better able to integrate care in our strategic considerations in a fashion that reflects the way the patient experiences them. Very often, of course, a patient who gets ill might go to see their family practitioner, might be referred first for some diagnostics and then come back, maybe have to go on further and see a specialist, perhaps resulting in the necessity of going into the acute care system. Subsequent to that, maybe they would need one of our convalescent care beds or to be provided with home care. This is all about making sure the health care system performs as a system that works for that patient across that continuum

The work the deputy has been doing to retool the ministry to be more responsive and to operate more where they're thinking about patients is part and parcel of

the capacity created by the implementation of local health integration networks, a subject that I know we'll have a chance to speak more about as we move through estimates.

So just a few things that are top of mind, subsequent to the round of questioning we've been able to enjoy so far.

Might I just ask the Chair's indulgence for a two-minute break for my little jaunt down the hallway before we get into the questioning?

The Chair: Yes. We'll have a recess.

The committee recessed from 1733 to 1735.

The Chair: I'll call the meeting back to order

Hon. Mr. Smitherman: Mr. Chair, just before we go to questioning, I just wanted to mention that I got a bit more information on the Woodstock situation. The increase in the net would be projected to be—like I said, obviously equipment lists and stuff like that move around a little bit, but our very best expectation would be that the net upload would be $18 million, that Woodstock would benefit from $30 million in additional government resource for the construction of the hospital. I might see an additional commitment of $12 million on their part for equipment, resulting in a net uptake of $18 million that the residents would have had to pay for and that the government of Ontario will now contribute.

Thank you, Mr. Chair.

The Chair: That completes your response. Thank you very much.

Hon. Mr. Smitherman: I ran out of words.

The Chair: I find that hard to believe.

We have approximately 24 minutes remaining. I need two minutes to do business before we break. There are no votes expected today at 6, as I understand it, so we should be able to run the clock.

Mrs. Witmer, why don't you start with eight minutes?

Mrs. Witmer: All right. I was looking at the estimates for colorectal cancer screening on page 95, and I noticed there is a reduction of approximately 6.6% in the amount of money available this year. I wonder if you could explain the decrease to me.

Hon. Mr. Smitherman: Sure. The allocation in there is the amount related to a pilot program that I believe is being run by Cancer Care Ontario. The reality is that we're working right now on policy options—it's before me—with respect to bringing forward a colorectal screening program. I can assure you of three things: Firstly, it is our intention to move forward with such a program this year; secondly, it is a very challenging bit of public policy, especially because some of the circumstances—there are capacity issues—related to the provision of services like colonoscopies; and the third bit that I really want to tell you about, which is very relevant to estimates, is that this is one the deputy and I have got a hard bit of work to do around because we do not have in our estimates at present all the resource we will require. But it is nevertheless our intention to move forward with the program this year. At the time of announcement, we'll be in a much better position to offer numbers of the requirements for this year.

If we look to the horizon, in terms of a fully matured program—and this again is reflective of the fact that it's a piece of active policy work in our ministry right now—the orders of magnitude for an annualized colorectal screening program would be from about $40 million to about $70 million.

Mrs. Witmer: I guess what I heard you say is that we can expect an announcement this year—

Hon. Mr. Smitherman: Yes.

Mrs. Witmer: —and obviously the implementation would be over a few years?

Hon. Mr. Smitherman: It's going to have to be phased or staged, because there will be an absolute necessity of aligning and training health care professionals. The work we have done so far lends itself to obviously initiating this with the highest-risk Ontarians first. It's safe to say that in terms of the work we have to do at the ministry over the course of the next two or three months, or the summer months, the colorectal screening initiative would be one of our top five at the moment. It's having a lot of resource and energy dedicated to it at present.

1740

Mrs. Witmer: So if you don't have the resources in place currently and you're going to need extra funding, do you plan to have phase one this year, or would you be looking at 2007-08?

Hon. Mr. Smitherman: We would anticipate that initiatives we undertake this year would result in program spending this year. But I don't think I would be very well positioned to tell you what. Because of the necessity of the ramp-up, it would be our view toward having implementation initiated in this fiscal year, with expenditure requirements in this fiscal year. But I could not yet zone in on a number. Obviously, over the breadth of our ministry's budget, we'll be looking for the opportunity to help provide the resources that are required. In future years, this is a piece that the deputy and I have some work to do on with our colleague.

Mrs. Witmer: What is it that you need? I understand that there are resources that are needed. What are the resources that we would be short? I understand the gradual phase-in too.

Hon. Mr. Smitherman: I think the deputy could speak well to those, especially the health professions.

Mr. Sapsford: The proposed project includes two parts. The first is dealing with a laboratory test, testing for hidden blood and, where there are positive results, to then refer those people on to either sigmoidoscopy or colonoscopy, a separate intervention.

So there are two aspects to it. The first is creating the program that will do the blood testing, and it's proposed that this might be handled by mail. We want to coordinate that, of course, with general practitioners and other kinds of primary care clinics. The second piece is really where the capacity questions come up. The rates of positives will generate many thousands of additional procedures across the province. One of the things that was understood during the pilot project was that we had

to provide for additional volume for colonoscopies and so forth.

Estimating the volumes and then providing the capacity in a variety of communities to take on that extra volume of procedure is really where the resources are required. There are a number of medical professionals who do that kind of work. But, as well, we've identified a role for nurses, so there's a training program being established for nurses to undertake sigmoidoscopies, which is partly as a result of anticipating this kind of screening program.

It takes time to identity the resources, to do the training, to implement working with Cancer Care Ontario as well as other hospitals and other clinics. That's why we're taking the better part of this fiscal year to begin the planning process. So as the minister said, toward the end of the fiscal year we hope that we'll be able to see the beginning elements of that program, and then, over the course of the next two or three years, more and more people identified and included in the screening process.

Hon. Mr. Smitherman: I might just make two other brief points. We're the first one out of the gate on this. A lot of times you start to kind of model something and they've got a model over here, and you can think about it or tweak it. But on this one, there's no other province or territory that has undertaken very much that guides us. That's one challenge.

The other thing I just want to tell members of the committee about is that we want to make sure—it's a big province out there and this is obviously going to have quite a few people involved in it. We want to make sure the model that we develop seeks as best as we possibly can to provide that in a geographically equitable way. This is another consideration that we want to make sure that we get right so that people are not asked to travel distances for, let's face it, a procedure that you'd probably prefer to get a little closer to home.

Mrs. Witmer: I appreciate that, and I—

The Chair: That would be the time.

Mrs. Witmer: That's it?

The Chair: I'm afraid so. Ms. Martel.

Ms. Martel: I wanted to ask some questions about funding for long-term care. The ministry announced about $155 million this year. Homes are receiving an increase of about $1.07; that's 98 cents for nursing and nine cents in programming. That would be about $29 million, if you take that across all homes. Can I ask where the balance of the $155 million is then going?

Hon. Mr. Smitherman: The deputy can provide you with more of a breakdown.

Mr. Sapsford: The $155 million is what I'm not following in the estimates. The increase is $91 million, which I can break down for you if you're interested.

Ms. Martel: I apologize, Deputy. I thought the ministerial announcement was for $155 million for this fiscal year. If I've made a mistake, I'm sorry about that.

Mr. Sapsford: I'm simply looking in the estimates. Some of the $91 million was for acuity and wage stabilization, as would be normal. That amounted to about $41 million or $42 million. There's an amount allocated for other accommodation, and that was about $22 million. Then an offset to the municipal taxation was the balance of the $91 million, which was a $33-million estimate, for a total of $91 million, a 3.3% increase over last year's estimate.

Ms. Martel: The $22 million for other accommodation would be for new homes that are coming on stream?

Mr. Sapsford: No; related more to the "other accommodation" vote, so for the hotel costs related to homes. We have envelopes, so the first one was more for the care envelope.

Ms. Martel: It was my understanding that it was a 98-cent increase in nursing and nine cents in programming. Can I get some clarification, then, on the other accommodation?

Mr. Sapsford: Okay. I'll do that.

Ms. Martel: Because the information that I had said there was nothing slated for either food or the accommodation envelope. If you can just get me some clarification, that would be great.

Mr. Sapsford: Sure thing.

Ms. Martel: That leads me to a discussion the minister and I have had with respect to promises around long-term care. Just in case, I brought another copy of the election leaflet that makes it very clear, Minister, that one of your own, who is a backbench member now, said very clearly that the government would invest in better nursing-home care, providing an additional $6,000 in care for every resident. In fact, the leaflet was left in a long-term-care home for all staff, residents and family to have a good look at as they made their decisions about voting in the last election.

If you look at that specific promise and then you look at the amount of money that's been allocated over the last three years, there certainly is a shortfall in terms of investing in better nursing-home care, providing an additional $6,000 in care for every resident. I think both organizations that deal with long-term care have been very clear about their concerns in this regard.

This is from a press release put out by OANHSS on March 23, the day of the budget, where it said as follows:

"Over the last three budgets, the Liberal government has raised the amount of annual funding going directly to care by about $2,000 per resident. This compares to a promised increase of $6,000—a promise made by the Liberals during the last provincial election." OANHSS estimates the funding shortfall in the sector is now $450 million a year.

As well, after the budget and the announcement of funding for long-term care, Ms. Sullivan, the Ontario Long Term Care Association, said on April 3:

"It is clear that both families and residents strongly disagree with any perception that government has addressed long-term-care service levels and that, for them, this is an issue of care, respect and dignity for those who built this province."

My question is, at what point will the government make good on the promise that was made during the election campaign to provide better nursing-home care and, in that regard, to provide an additional $6,000 in care for every resident?

Hon. Mr. Smitherman: The honourable member has changed the nature of her question, because when she first asked the question she talked about our health platform. I have a copy of our health platform, and that piece of paper is not part of our platform. That's the way I've answered that question every time it has been asked.

We have made a 34.1% increase in our funding for long-term care since our government has had the privilege of being the government in the province of Ontario. This has resulted in the hiring of 3,140 new staff working on the front lines in long-term care. Alongside that initiative, we've done many, many other things related to long-term care.

The answer to the honourable member's question is that we continue to make progress, set against a wide variety of commitments. These stakeholders, like all of our stakeholders, are in a position where they would like more resource. We're not in a make-believe world where you can simply resource the expectations written in a press release, but if you look at it over a period of each and every year that we've brought a budget in, we've enhanced the resources for long-term care.

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We've fulfilled our commitment with respect to rolling back the increase in the copay that the Conservatives had brought in. They had made an announcement about a 15% increase; at the end of the day they did only half of that, 7.5%. Through a freeze of copays which has taken shape through the life of our government, we have not increased at all the amount that individuals pay. We've taken those portions up. We still provided the amount to the long-term-care sector, but we've fulfilled that commitment on behalf of the residents. We've now done the second increase in the comfort allowance. We've certainly increased the amount of money available for food in the long-term-care sector.

We've brought in a 1-800 action line that has resulted in about 8,500 phone calls and a very speedy triage system to go out and enforce appropriate standards and expectations. We've obviously put information on a public website that provides people with a glimpse into the service record of the homes. We've equalized the physiotherapy capacity in long-term care so as to create an equal system, rather than the one that had the residents in 200 long-term-care homes receiving no support whatsoever related to government-resourced physiotherapy. And we've instituted no-announcement inspections, one of those things that's long-standing.

So yes, there's more to do on this file, as I have the privilege of saying very often, but we have made a 19% increase from 2003 to 2005 in the amount that we provide for raw food. I'll just remind you again, you had a record when you were in government: You left the raw food costs in long-term care stagnant while you did increase them for people who were incarcerated. I just think it's appropriate when we're considering issues like this to be a little bit more forthcoming in terms of your own personal record on matters, including and especially related to food.

Ms. Martel: If I might, Minister, you didn't make any change in the food budget for this fiscal year, and every time I've asked this question about the promise, it's been in the context of an election promise. I didn't say today "according to your health platform," and in the questions that I have raised in the Legislature I haven't referred to the health platform either. I have referred to this document, which was an election leaflet put out by one of your own who is a sitting member today. It was put out in a long-term-care home for everybody to see in terms of commitments that the government was making to those staff and to those families and residents, and I want to ask again, because it is very clear that there's a very significant shortfall between what was promised and what has been delivered. You're into the third budget now, and after the third budget you are only one third of the way to enhancing care in proportion to $6,000 per resident per day in terms of additional care—you're only one third of the way. Is the rest of the money going to come in the next year so you can actually keep this election promise? Yes or no?

Hon. Mr. Smitherman: The honourable member has been here a heck of a long time and she knows quite well that most governments don't announce their next year's budget 10 months before it's due, and I'm not going to today. I can tell the honourable member that it's reasonable to expect that our government, which has increased funding for long-term care every year—5.9% this year, 34.1% since coming to office, for a total of $740 million in new investment. We make a decidedly significant commitment to the provision of long-term care, and on this issue, like all others, there is more opportunity and more to be done.

One of those elements yet to be done that we've spoken about today is coming in terms of a new piece of long-term-care legislation, and I can say to the honourable member that she's right to apprise us of the fact that there are yet opportunities for us to move forward with additional resource for long-term care and it's appropriate to assume that there will be some, and the budget that comes next will provide us with better answers to what those absolute numbers look like.

Ms. Martel: Then I wonder if the second promise that was made with respect to residents in long-term-care homes will also be kept, and that was a promise that the government made to reinstate a minimum of 2.25 hours of daily nursing care per resident per day. That was certainly a promise that was made in a letter that Mr. McGuinty sent to SEIU and a questionnaire that he responded to where he made it very clear that the government was going to reinstate, via regulation, a minimum standard of 2.25 hours. I believe the standard should be far higher than that, because I believe that residents who are going into long-term-care homes now have much more complex needs, but the fact of the

matter remains, there is no regulation in place at all right now determining the number of hours of hands-on care that should be and must be provided to residents. There was a very specific promise made by Mr. McGuinty in the last election. We have seen no change in regulation, no standard that is in place. When can we expect you to keep that election promise and to reinstate at least the 2.25 hours of hands-on care, if not have a standard that provides for even more care for these complex residents coming into long-term-care homes?

Hon. Mr. Smitherman: Firstly, with respect to complex residents, the deputy's already indicated that one of the things that we seek to do is make sure that we have resources that are aligned with acuity levels. We've enhanced the capacity for long-term-care homes to get the resources they need, most especially for those residents who are requiring a higher degree of support. I think that obviously the issue with respect to regulation stems from legislation, and that's an issue that we've discussed quite fully.

I note that the honourable member is now increasing the level of care beyond the level that your government had, but of course your record in government is what stands out to us. So yes, I think that the issue with respect to—

Ms. Martel: You have no regulation.

Hon. Mr. Smitherman: —regulation will be part of that conversation. We have of course restored 24/7 coverage of registered nurses in the long-term-care sector, and as a result of funding initiatives where we've actually made sure that the dollars were spent on staffing, there are at least 682 additional nurses providing care to our loved ones in long-term care.

Taken as a whole, if we look at the initiatives that we've undertaken with respect to long-term care; if we look at the amount of additional resource that we've put in there; if we look at the new positions that's resulted in; if we talk about the new regulations, including those for 24/7 RN and minimum numbers of baths per week; if we look at new standards for skin care, wound management and continence care that have been in place since the beginning of 2006; tougher inspections, a 1-800 action line, increases in the comfort allowance, frozen copayment, public reporting website, equalized access to physiotherapy, 3,827 ceiling lifts—all across the breadth of long-term care is a very ample example of our government's commitment. We have, as has been well documented here, even further opportunities to enhance the array of initiatives that have led to care so far.

The Chair: Thank you, Minister. I'd like to recognize Mr. Wilkinson.

Mr. John Wilkinson (Perth–Middlesex): I thought we'd have about eight minutes, as you were discussing. I know we're close—

The Chair: I thought so too, but I didn't want to interrupt the minister.

Mr. Wilkinson: Neither would I; I would never do that.

Mr. Chair, since we'll be back here tomorrow, if we could pick our allocation when we come back—if that works for the committee, we're more than happy to do that. We could deal with the business matter—

The Chair: It works for the Chair.

COMMITTEE BUSINESS

The Chair: If I might engage the committee in a small matter of business, I'd feel comfortable if I had some sort of agreement or resolution with respect to the committee's interest in sitting in the intersession. We've been asked by the House leaders to notify them. I can roughly suggest to you that we have only completed three of the 12 estimates. If we do not take time in the intersession, we will fall short on at least three and, in likelihood, four. That would be, for sure, public infrastructure renewal, and colleges and universities, as well as municipal affairs and possibly energy. So if we were to choose some time, and I would say to you if we did one week, there's a good likelihood we would complete our estimates by the prescribed time in November that the House rules set out for us. So I'll entertain a very brief discussion, but I'm looking for consensus. Do we wish to sit in, in all likelihood, September for a week, maybe two, but I suspect just one week? Any discussion?

Mr. Wilkinson: On behalf of the government, we're more than happy if the Chair writes to the House leaders and requests that we—

The Chair: Thank you very much. Ms. Martel?

Ms. Martel: I don't regularly sit on the committee; I'm in for the health estimates. I'd like to check with the critics from the other areas that would be impacted.

The Chair: I have checked with several of them and they're most anxious to get at their ministers with their questions. Would you be guided by that?

Ms. Martel: I'd prefer to talk to them myself, if you don't mind, Chair, because I know that one of them will involve the leader if you're doing energy, so I'm not sure if you've talked to him or not about that.

The Chair: Thank you. I will make this the first order of business tomorrow before we begin.

This meeting stands adjourned until immediately following routine proceedings tomorrow in room 228. Thank you.

The committee adjourned at 1800.

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