ISSN 1181-6465

Legislative Assembly
of Ontario

Second Session, 38th Parliament

Assemblée législative
de l'Ontario

Deuxième session, 38e législature

Official Report of Debates (Hansard)

Wednesday 14 June 2006

Journal des débats (Hansard)

Mercredi 14 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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Telephone 416-325-7400; fax 416-325-7430
Published by the Legislative Assembly of Ontario

Service du Journal des débats et d'interprétation
Salle 500, aile ouest, Édifice du Parlement
111, rue Wellesley ouest, Queen's Park
Toronto ON M7A 1A2
Téléphone, 416-325-7400; télécopieur, 416-325-7430
Publié par l'Assemblée législative de l'Ontario

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON ESTIMATES

COMITÉ PERMANENT DES BUDGETS DES DÉPENSES

Wednesday 14 June 2006

Mercredi 14 juin 2006

The committee met at 1600 in room 228.

MINISTRY OF HEALTH AND LONG-TERM CARE

The Chair (Mr. Cameron Jackson): I'd like to call to order the standing committee on estimates. We have approximately four hours and 50 minutes remaining on the estimates of the Ministry of Health and Long-Term Care.

I have two housekeeping matters that I'd like to move the committee through rather quickly, if I may. The first is, we have, I believe, from the subcommittee members full concurrence that we will write to the House leaders and seek time during the intersession to complete a certain number of ministries. All those in favour? Opposed, if any? That is carried.

The second matter: I had a conversation last evening with Minister Watson, the Minister of Health Promotion. He has written to me, as I requested, last night, substantively that on Wednesday, June 21, he has a long-standing commitment to host a federal-provincial-territorial sports ministers' meeting in Ottawa. I'm sure he'd rather be there with his running shoes than here in his suit. If I have the concurrence of the committee, it would be my recommendation that we not sit on Wednesday of next week and that we will make that time up. We can then start that ministry fresh during the intersession. I will entertain brief discussion. Seeing none, all those in favour? Opposed, if any? That is agreed. Thank you very much, committee. We'll have the clerk convey that good news to Minister Watson.

Now, I'd love to recognize you, Mr. Wilkinson, for eight minutes. You were just ahead of yourself. I understand that. Please proceed.

Before I begin, Deputy, do you have any additional information from the several questions that were raised from yesterday?

Mr. Ron Sapsford: No. They're in preparation, but I hope to be able to table some on Tuesday with the committee.

The Chair: All right. So in your opinion, you won't have any done for today?

Mr. Sapsford: Correct.

The Chair: Okay. Let me just have a look. Is there difficulty with these? Like the hep C one I'm looking at: Is there a serious problem with a simple question about the balance remaining in the fund? If you need an extra day, maybe we should not sit on Tuesday and then sit on Wednesday to give you an extra day to get the answers.

Mr. Sapsford: Fair enough. Let me just regroup here. I can speak to hep C, actually. The question was—

The Chair: It's fine. I'm looking more for your instruction as the deputy to complete some of these rather simple questions. The minister conveyed a sense of full co-operation yesterday, so I was a little surprised not to have at least one or two of those done. If you can get some done before today is out, that would be extremely helpful; if not, tomorrow. We would like to get those as soon as possible.

Mr. Wilkinson, I'd like to recognize you now, please.

Mr. Sapsford: Mr. Chair, just a clarification. You're suggesting they be tabled in writing, then, as opposed to verbally?

The Chair: That's generally what the requests are, and then they're a lot easier. The member may not wish to revisit the question based on your response.

Mr. Sapsford: Fair enough. Thank you.

The Chair: Thank you very much. Mr. Wilkinson, you have the floor.

Mr. John Wilkinson (Perth–Middlesex): Minister, thank you for coming and appearing in estimates. We appreciate that. I'd be remiss if I didn't start by saying, as the member for Perth–Middlesex, we appreciate the work that your ministry has done in our riding.

I just want to revisit one issue. We were talking yesterday about the new funding formula. In my discussions with my hospital in Stratford, for example, they're very positive about that, and I know there was some characterization about that yesterday, particularly around the situation in Woodstock. I read some press reports about the situation at Royal Victoria. I was just wondering if you could bring us up to date on that. That would help me.

Hon. George Smitherman (Minister of Health and Long-Term Care): Sure. We had a chance overnight to work somewhat more toward the broad answers that are requested by committee. I have some analysis on a few more hospitals, but as the deputy's mentioned, obviously we'll be working to provide more information to the committee.

On the issue of Woodstock, though, I want to correct yesterday's record; I was misinformed. I originally indicated that the net benefit to Woodstock General Hospital

from our move to a 90-10 formula would benefit that hospital and its local community to the tune of at least $30 million. Subsequently, I indicated that that wasn't net, that in fact the net was lower.

The correction I want to make is to indicate that the first answer was indeed right, that, by analysis, even considering the hospital's responsibility with respect to purchase of technology and equipment, the net benefit to the Woodstock hospital from an increase in our cost-share formula to 90-10 will represent a benefit to that community of at least $30 million.

Mr. Wilkinson: Minister, I was at Stratford city council on Monday night. It was quite interesting because, when I was first elected, the very first meeting I had with Stratford city council we were talking about their number one issue, which was, of course, that they had been downloaded, and the discussion centred around the future of Stratford General Hospital and its redevelopment. What that municipality told me at the time was, "You know what? You guys"—the province—"should be picking up all or the lion's share of construction and let the community deal with the furnishings and the equipment, because our foundation at the hospital is set up to raise money for equipment and furnishings. And it's not the city's hospital, it is the province's hospital."

If we could just go to that, there would be, as well, some equity, because as you know, Minister, there was a range of arrangements about 50-50 shares; some places were 60-40. It depended on what was in and what was out. Was it construction? Was it equipment? Which equipment counted? It's pretty simple for us to say it's the construction and the development costs.

I just want to give you some feedback. What I've heard back in my community, both from the municipal sector and from the foundation, is that this is the way it should have always been. It's just a lot simpler for the people in the community who have to raise money to understand that, and it does put the onus on the construction, where it belongs.

I'd like to turn to the question in your estimates about community mental health. I was able to make an announcement recently in my riding. I see that on your community mental health line there's an increase of almost $69 million. I know that historically there were no increases in the period from 1992 to 2004. I had a chance to have an event with the Canadian Mental Health Association in my riding, with John Robertson, the executive director, and we went over this.

They were particularly happy about additional funding for mental health, and particularly for new supportive housing beds. The need in my community was great. I know we're in a competing environment for money within your own ministry. So can you tell me more about the government's intent on allocating additional spending for community mental health compared to all the other priorities that you have?

Hon. Mr. Smitherman: Firstly, in a certain sense, of course there's a competitive environment for every dollar that we have available. But the strategy we've tried to employ with respect to health care funding is very different than the one we inherited from the previous government. In that circumstance, some program areas received very significant increases for a four- or five-year period, and others, when we came to office—community mental health is a very big example—hadn't received a penny of additional resource for 12 years, not even base budget allocation to address inflation. So we had a circumstance where hospitals had received about 10% a year for the five years prior to our government coming to life, and community-based mental health had not received a penny.

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The obvious circumstances are that, if you don't provide community-based mental health supports, your hospitals are going to be busier; it's a little bit of a self-fulfilling prophecy. Accordingly, what we sought to do was to make investments that recognize the continuum of care and recognize that if you invest appropriately in the community, if you provide supports for people at a point, perhaps, when they're just starting to feel like they need to talk to someone rather than at the point that they're experiencing an acute mental health challenge, that's better for the patient, obviously, and in the long term tremendously beneficial for the health care system.

There are two different programs we've made significant investments around. One is a $185-million investment over four years. We announced that when we first came to life as a government. That has supported the creation of a lot of additional capacity at the community level, including things like safe beds and ACT teams, which are well known in communities, to have an interdisciplinary team of people who can provide a very comprehensive array of supports to people, including and especially those who are suffering from serious mental illness. This is allowing us to address the needs of tens of thousands of additional patients or clients.

In addition to that, soon after coming to life as a government, we came to realize that 37% of all those in our criminal justice system were people experiencing mental illness, a lot of people with mental illness ending up on remand or in jail simply because they didn't have housing. So we've recently announced the second wave of what will be $50 million now in annual funding that is providing tremendous support to assist people who are at risk of being involved in the criminal justice system. Yesterday, I mentioned that that, in less than a year, has already reduced the remand list at one court in Scarborough by 36%.

One element of this that we've brought forward is supportive housing. This is being utilized in the form of shelter subsidies and can work in more than one way. For some of our agencies, they will simply obtain housing in a private environment, for which there is reasonable access in many parts of the province now, and provide supports to people there on a case-by-case basis. In other instances, organizations have pooled shelter subsidies and used that and the revenue stream associated with it to

leverage the actual purchase of a building, which is then converted for the purpose of providing supportive housing. One way or the other, this has produced I think about 2,000 units of supportive housing, which is an awfully good way to address some of the challenges that people with mental illness are experiencing in our communities.

Anecdotally, we hear from police officers that in many circumstances where, prior, they had no option except to write people up and lock them up, they can now make a phone call to some of the community-based resources, things like safe beds that allow people to have, for a period of time, a safe bed with appropriate support so they can be stabilized and triaged for further care. These are providing a lot better response than the ones that had us locking up people with mental illness.

We have lots of things we're proud of, but this is one of those things I feel is making as big a difference as any other in terms of the investments we've been able to make as a government.

The Chair: Thank you very much, Minister. Thank you, Mr. Wilkinson. I'd like to begin half-hour rotations, if I may. I will begin with Mr. Miller.

Mr. Norm Miller (Parry Sound–Muskoka): I'm pleased to have this opportunity to raise a few health-related issues, particularly as they relate to Parry Sound–Muskoka.

Minister, in April, we appreciated you holding a meeting with Dr. Peter Istvan from the Parry Sound hospital to do with the nursing stations in Parry Sound–Muskoka. We're kind of unique in that we have six nursing stations. Two were started fairly recently, in 2003, they being Rosseau and Whitestone. As you're fully aware, the programs under which those nursing stations are funded are different. I believe the Rosseau and Whitestone programs were started on a pilot project. I know that in our meeting that we had in your office, you didn't think it made a lot of sense to have different silos and different funding levels for nurse practitioners and nursing stations that are essentially doing the same program. Probably the thing that's most challenging is the salary levels in the funding for the Rosseau and Whitestone nursing stations at this time. In their funding envelope, they received just $72,500 toward salaries and also no vacation relief. They work extremely hard, but we can't expect them to work the whole year without any break and vacation or some budgetary means by which they can get a break. I'm just wondering if there's been any progress made in that funding.

Since we had the meeting in April, on Nursing Week I actually visited the Rosseau nursing station and I can communicate to you that Donna Kearney, the nurse practitioner, is doing an excellent job. There were about 50 people out to a meeting to thank her for the work she's doing. Both Rosseau and Whitestone are seeing greatly increasing numbers of people using the services, but there are some sustainability challenges with the different levels of funding, and I'm just wondering how progress is going.

Hon. Mr. Smitherman: I can tell the honourable member that subsequent to the meeting we had the chance to have here in Toronto, I was also asked, I believe by a councillor or perhaps a mayor from your communities, about this at the FONOM meeting in Blind River—

Mr. Miller: Likely Dave Conn, I would guess, the mayor of Seguin council.

Hon. Mr. Smitherman: Yes, it could quite possibly be. I do not have much further to tell the honourable member, except that I think you remember from the meeting that ministry staff were there and I gave them direction to go back and take a look at what we could do to create a program that had greater consistency. I know there is a rationale that the ministry had based their decision points on, but in retrospect, I believe it's one that if we take a bit of time, we can create a model that is a little easier to work within for communities. That's the first part, and that's not news to the honourable member.

One of the options that is under active consideration is that, as the member will know probably better than me, I believe there's a family health team that has been announced as part of a third wave of family health team announcements in that area, and one of the things we're looking at is the opportunity perhaps to use the foundation of the family health team to address some of those unique circumstances like coverage capacity during holidays, and also to try and rationalize the administrative cost.

So while I can't tell the honourable member what resolution we've landed at, I can tell him we are seeking a resolution that is designed to address the concerns he's brought forward on behalf of his community, recognizing that these are also occurring in not tons and tons of other places, but certainly in a few other places in Ontario, and we would all benefit from a policy that was a little more standardized across the board.

I'm hopeful we'll find a resolution that's satisfactory. That's the direction we're working on, and we'll endeavour to keep the honourable member posted on that as progress is made, but I don't have anything further to report on that at present.

Mr. Miller: Thank you, Minister. The second question has to do with the northern health travel grant. Again, I appreciate the minister's help with the situation I had with one constituent who lived in the north, but had a physician who wasn't from the north. You've made some changes to identify that residency should be the determining factor for coverage of that service, and I appreciate that.

I guess my big complaint about the northern health travel grant is that it still is mired in bureaucracy in terms of process, and this has been ongoing for a number of years, where, for example, if you're a chemo patient and you have 20 visits required, you have to get 20 signatures from the treating physician, which seems kind of ridiculous. As I say, it's been going on for a few years. I've raised this issue before. I'm sure if you're a chemo patient, that's about the last thing you're going to be

thinking about under those circumstances. I'm just wondering if efforts can be made to make the system less bureaucratic. I would think that in a situation like that, one signature noting 20 treatments required might be the thing that makes sense. I also note that within that program, if someone's rejected and they've gone and gotten the 20 signatures, they end up getting 20 letters back. I've had them in my hand before; you'll actually get 20 letters saying the same thing for each individual trip, coming back and rejecting you for it. That's one issue, just the bureaucracy involved in the process.

The other sort of bureaucratic item is that for those residents in my riding who are in the north but aren't able to have a northern physician, they must provide proof every six months that they are attempting to obtain a northern physician, which seems a little onerous to me, to have to get that proof every six months. It's probably onerous as well for the physicians who have to provide the proof. If you could comment on that, I'd appreciate it.

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Hon. Mr. Smitherman: I'll try to address these from two different perspectives to tell the honourable member that I do have some policy work that's been done, driven by the government caucus from the north, and a recent report that came from our colleague from the riding of Sault Ste. Marie looking at opportunities to address some of the bureaucratic challenges that you've addressed, which have been long-standing in that program. I'm not saying that is acceptable. I find it unacceptable and the circumstances that you outline are, from a common sense standpoint, just missing the mark. Accordingly, we're going to take a look, a comprehensive review of the program with a view towards seeing what we can do to enhance the timeliness of it and its accessibility from the standpoint of paperwork barriers and all of that, and also take a look at some of the benefits that it offers.

Obviously, people in the north experience higher costs associated with fuel. There are challenges associated with the program that have been highlighted for a long time, including its rigidity around issues like no coverage whatsoever for accommodation costs. I'm not in a position to make an announcement today, but I do want to signal to the honourable member the desire on the part of the government to be able to move forward with some alteration to the travel grant in a fashion which is designed to address some of the bureaucratic rigmarole and also some of the eligibility, because we think there are opportunities for improvements on both of those counts.

Just on the requirement associated with people continuing to look for the opportunity to get a doctor, I do think it's important, because this is a very fluid environment, that we keep people attuned to new opportunities. A small example would be that next Friday night a new family health team is celebrating its opening in the community of Haliburton. This is a community, just as one example, that's got a high proportion of seniors. Already, although that family health team is not fully staffed, 655 patients who in that community were previously orphan patients now receive care in that family health team. In the community of Peterborough, the family health teams—five of them, actually, coming to life there—although not fully evolved yet, are already providing care to 3,452 people who previously didn't have access to doctors.

So we do have a fluid state in the province of Ontario. We're enhancing access to primary care. Of course, we're almost doubling the number of community health centres that we have. All of these things, taken together, do mean that there are situations where people don't have access to primary care that are being resolved. Accordingly, we want to make sure that people remain attuned to it. Whether the six month thing is right or not would be part of the kind of criteria that we'll take a look at in the review.

Mr. Miller: Thank you. One final question before I pass it on to Mr. Dunlop. I have a resolution from the municipality of McDougall to do with long-term-care funding, basically saying:

"Whereas the provincial government has raised the annual funding by $2,000 per resident versus its election promise of $6,000; and

"Whereas these unfunded increased costs are being downloaded to local municipalities...."

They're concerned about increased costs and they're also concerned about the government honouring its promise, made in the last election, to increase funding for long-term care by $6,000 per resident. I am passing that resolution from the township of McDougall on to you and look forward to your response.

Hon. Mr. Smitherman: At the beginning of estimates yesterday, we had a good chance to talk about issues with respect to long-term-care funding. I think the first thing that needs to be said about their resolution is that the second element of it that references "downloaded" is a bit of an irresponsible use of that word. You can, obviously, raise questions about the amount of resource that we've transferred to long-term care. So far for our government, that amounts to $740 million in additional resource, but of course, part and parcel of that have been annualized increases for the provision of long-term care. So I think there has been nothing—

Mr. Miller: If I can interject on that level, I think what the local municipalities—to bring it down to the Parry Sound level, there are seven municipalities, if I have the number right, in the Parry Sound area that, for example, fund the Belvedere Heights long-term-care facility. I met with the board of Belvedere Heights, and this year they're facing a deficit of roughly $760,000. That deficit ends up being picked up by the seven small municipalities. I think that's what they're talking about, that they're seeing Belvedere Heights coming to them, asking for greater sums of money. That's essentially what they're talking about.

Hon. Mr. Smitherman: I get the point, but each and every one of 618 long-term-care operators has some obligation and responsibility associated with the decisions they make around how they operate their home. Obviously, on the very same funding basis, there are a

variety of other providers in Ontario that are not in a position to reach out to a local municipality to pay costs towards that, and they manage their affairs quite effectively. But I take the honourable member's question.

On this point, what I had a chance to say yesterday was that the investments we've made in long-term care have allowed more than 3,000 additional people to be employed in long-term care for the provision of care to our loved ones. We've moved forward with a wide variety of other initiatives on the long-term-care front. But, like the opportunity exists on virtually every file that we have in health care, long-term care stands as one of those where, of course, additional resources are much desired by all who operate in that element of the system.

The point that I think is important to make is the one that I made in response to a question from Mr. Wilkinson, and that is that what we've sought to do as a government is not just to invest in one or two elements of the health care system, but to invest across the board, and to recognize that they are very much independent. That's why I'm proud to say that our track record on investments is very good on the community sector, on the institutional sector, on the primary care sector. We're seeking to invest across the breadth of the system so that the system elements can perform well together, but we recognize that this is one area where there is a very strenuous appetite for more resource.

Mr. Miller: Thank you for your comments. I'll pass it on.

Mr. Garfield Dunlop (Simcoe North): Thank you, Minister, and all the staff from the ministry who are here today as well.

I have three questions. I was going to read them into the record. I'd ask if we could possibly get a response back from the ministry; some kind of written form would be fine. And, Minister, if you have any comments to add, that would be fine as well.

All of the questions involve health care stakeholders within the county of Simcoe. They've sort of come forward in the last few days to ask me to make a few comments. Part (a), county of Simcoe—I'll read this in:

"Due to the long-term-care bed shortage in the county of Simcoe, the county has written a formal proposal to the province for 43 additional long-term-care beds to ease the burden placed on this area. The county of Simcoe has the longest wait-list in the province of Ontario based on Ministry of Health and Long-Term Care utilization reports in both 2005 and 2006 and it is rapidly increasing. County council has determined that its Penetanguishene long-term-care home"—that is the Georgian Manor—"can be redeveloped to accommodate this increased demand.

"It is not without precedent that the province should acknowledge a critical shortage of beds and seek to affect a solution. In April, Minister Smitherman announced a new LTC facility to be built in the city of Kingston to ease a chronic shortage of beds in that community.

"Will the province reconsider their decision not to award new beds in this area due to the critical nature of this shortage? The county views this as an excellent opportunity to work with the province to improve local health services and build a stronger community."

Minister, that's certainly not to say that we don't appreciate the interim long-term-care beds that were made at the Huronia District Hospital this past winter. Those are basically the questions. If anybody would like to make a comment, or you can get back to me later; that would be fine as well.

Hon. Mr. Smitherman: I would say two things to the honourable member. As you've mentioned, we have recognized that Simcoe county has challenges in that sense. There are a variety of places in Ontario where there's a desire for greater long-term-care beds. I would make two points. Firstly, we have opened the 36 interim beds, as you've mentioned, and those will remain in place for whatever period of time they're required. But I do think that part and parcel of the strategy that you need to be mindful of, even when you speak about the situation in Kingston—firstly, when the previous government went through the round of allocating 20,000 beds, pretty well everyone would take a look at the numbers and say, "I think they left Kingston off the map." It really does seem that Kingston stands out as a very clear anomaly in terms of the proportion of beds in that community. That's why we've made an announcement there.

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But the other part of the announcement that we made in Kingston that I want to highlight to the honourable member is that we provided additional resources to the community care access centre to enhance its capacity to provide home care. One of the things we really do feel is that, while it is appropriate, of course, to have long-term care as an option for some, we're not convinced we have as a province maximized our capacity to provide care to all those who would prefer to receive it at home. In other words, by enhancing the capacity of home care, to perhaps move it back into some of those areas where it's been somewhat forgotten about over the last decade or two, we have the capacity also to support some people. Many people and many of our seniors are expressing in a very strong way their desire to age in place.

So I just want to highlight to the honourable member a recognition of the challenges in Simcoe county, a commitment to have those interim beds there on an indefinite basis for whatever period they might be required and to continue to look for strategies that can better address the needs of our aging population, but just to keep alive in the consideration the opportunity to look to enhanced home care to provide for some of those people who would otherwise have no option but to arrive in our long-term-care homes.

Mr. Dunlop: Thank you very much for that answer. The second question—again, you're familiar with this—revolves around the Penetanguishene Mental Health Centre and the Oak Ridge redevelopment. You and I toured that not too long ago; I think it was the end of March.

These questions are really coming from the community. The community's quite concerned about the future there.

The Ministry of Health and Long-Term Care owns and operates the province's only high-security mental health facility in Penetanguishene. More than 200 mentally ill men each year are confined in this facility. Recently, the Canadian Council on Health Services Accreditation determined that the Oak Ridge facility did not meet minimum standards of care because of a deteriorating physical plant. Accreditation has been granted on an interim basis pending a decision from the government on redevelopment. Failure to redevelop the site would not only result in continued deprivation for the mentally ill individuals housed there, but would also directly impact the jobs of 800 or more constituents of mine in Simcoe North.

(1) Is it the intention of the government to commit in this fiscal year the funds necessary to proceed towards redevelopment of Oak Ridge, Ontario's only maximum-security psychiatric hospital?

(2) If so, what is the amount committed this fiscal year and what assurances can I provide to the patients of this hospital and to my constituents of fiscal commitments in the coming years sufficient to complete the project?

If no, what are the government's plans to address the consequences of the mental health centre losing its hospital accreditation and the resulting difficulties with the recruitment and retention of professional staff, as well as the maintenance of academic and professional affiliations? How will the government counter the loss of Ontario's reputation as a caring province with a modern health care infrastructure?

Again, I'm not expecting an answer on that. If the ministry can get back to me.

Hon. Mr. Smitherman: There are two different issues there, and I think I can address one somewhat better than the other. Firstly, I would say to the honourable member on the issue of the government's commitment to the Oak Ridge facility, and in its current Penetanguishene context, we have no consideration associated with the transfer of that facility from that area, first and foremost.

Mr. Dunlop: That's good news. Thank you.

Hon. Mr. Smitherman: Now for the bad news. The member asked a very direct question with respect to this year's budget. I can say to the honourable member very candidly that the Oak Ridge project is not in the government's capital plan for this year, but we are working diligently. I'm not sure if the deputy has anything to add. Obviously, one of the reasons that I went to Oak Ridge for our tour recently was to be able to eyeball it, to have a chance to meet the staff and to hear from them first-hand their experiences and, frankly, their challenges in dealing with a facility that has for many decades now really been outdated.

The honourable member, coming from Simcoe county, will know that we're making very big capital investments in Simcoe county, with the ongoing capital construction at the honourable member's most local hospital in Orillia, and also proceeding with plans in Barrie. There are lots of pressures there. So we're going to continue to work in a fashion that finds a go-forward for the Oak Ridge site, but I can say very candidly to the honourable member that this estimates process, our 2006-07 budget, does not contain resources with respect to the capital redevelopment of the Oak Ridge facility.

I'm not sure, Deputy, if you have anything else to add.

Mr. Sapsford: Simply that we're continuing the planning and design work, and to share the concern about the accreditation status of the hospital. It's very much on the planning agenda of the ministry. As the minister said, I hope we can find a physical solution in the near future.

Mr. Dunlop: Thank you very much for that.

The final is a very short question—maybe more of a clarification to myself than anything else—and a couple of brief comments on it.

Last Friday, June 9, I received several calls from stakeholder constituents in my riding who had heard about the announcement that the Ministry of Health and Long-Term Care would cover 90% of the cost of new hospital construction. If you can explain the announcement in a little more detail; I haven't really seen a lot of paperwork on this. Would you clarify whether the planned expansion of the Royal Victoria Hospital in Barrie would qualify under this, and if the MRI building costs—you're very familiar with the MRI building—at Soldiers' Memorial Hospital in Orillia would also qualify. It's mainly just a clarification because a lot of my hospital people are calling me asking if we could find a little more detail on it.

Hon. Mr. Smitherman: First, I will describe the policy. The government has made a commitment to enhance the percentage of construction costs that the province of Ontario pays to 90%. This has ranged from 50%, 70%, 80%, depending on the circumstances, and it's our intention to go to 90%. We do that on a going-forward basis from April 1, 2006. So in very direct answer to my honourable friend, and to correct the record created by officials at Royal Victoria Hospital in a piece that ran in the paper today—

Mr. Dunlop: I didn't see that.

Hon. Mr. Smitherman: They've actually suggested that they weren't sure if it's beneficial to them, which is a bit odd because the circumstances at Royal Victoria are affected to the tune of at least $30 million to the positive for the local community. Obviously there is a very significant fundraising effort being made, with tremendous support from the county, the city and individual contributors, but we will have eased their way somewhat—well, quite considerably—with at least $30 million in additional resources coming from the province of Ontario as a net result of this.

The issue with respect to the MRI building at Soldiers' is one that I'm a little bit less certain about. I'm going to defer on that; I don't want to mislead. I want to make sure. My best instinct is that because it has not yet taken

shape—I'm not sure that it has. I don't think it's had its sign-off so I'm not sure—

Mr. Dunlop: No, it hasn't.

Hon. Mr. Smitherman: I will make sure that I get a very direct answer for you.

Mr. Dunlop: You mentioned county support for the Royal Victoria Hospital. It's really county councillors who have called me because they have a huge challenge if they're trying to meet their commitment to that hospital. It would be positive news to the county council if there was more money being put in from the province under that arrangement.

Hon. Mr. Smitherman: There's no doubt whatsoever that there are more resources coming. I do think it's important that before the county council or others decide to start backing away from commitments that they've already made, they give the hospital some additional time to work through its numbers, because the formula has a range of circumstances in it. It includes construction costs where we go to 90-10, but obviously with respect to equipment costs, we're looking to the local community to carry all of those costs. Again, on the analysis, best as we know, the numbers that have been determined or estimated to date, the net benefit for the greater community of Barrie and Simcoe county related to the Royal Victoria redevelopment would be at least $30 million.

Mr. Dunlop: I appreciate your comments, Minister. Thank you; that's all I have.

The Chair: You've got five minutes left.

Mr. Dunlop: Do you want to change chairs at all?

The Chair: No. Do you want to use the five or I'll stack it?

Mr. Dunlop: I have no other questions prepared at this time.

The Chair: Then I will recognize Ms. Martel.

1640

Ms. Shelley Martel (Nickel Belt): I wanted to go back to the nursing number sheet that was given to us yesterday and ask for some further clarification in that regard. The first question is, if I could get a breakdown from the ministry on the number of nurses in long-term care, the 682, of the RNs and RPNs that that figure makes up, that would be great. Secondly, if I can get a breakdown of the long-term-care homes—

Hon. Mr. Smitherman: How do you mean?

Ms. Martel: —that are getting those positions.

Hon. Mr. Smitherman: The first one's no problem, but I don't understand the second question.

Ms. Martel: The homes that are getting the positions.

Hon. Mr. Smitherman: Yes. I think this will all be worked based on surveying that we've done from them, so we should be in a position to provide that for you.

Ms. Martel: Great. Minister, yesterday—and you'll correct me if I'm wrong—I think you had mentioned that UHN had an 8% RN attrition rate. You had given a specific figure for a hospital with respect to attrition rates. I'm wondering if you have that for all hospitals, or do you have a general number that could be applied in 2004-05 and 2005-06?

Hon. Mr. Smitherman: No, it's just an anecdotal number. If we have any statistics like that, I haven't seen them. That's just an anecdotal number that's been provided to me by hospital administration, and because it's the largest hospital in Ontario, it's a number that has stuck with me. I only know it because I heard it and I've repeated it, but it was provided to me by either the past or current CEO of the hospital.

Ms. Martel: So that's not being collected either by the college or—it wouldn't be part of the reporting requirements as well that—

Hon. Mr. Smitherman: It might be. Part of the work we're doing right now with the task force that Tom Klassen is chairing is to give us the capacity to ask the right questions and collect the right information. As I expressed yesterday and as anyone who tries to work around all these nursing numbers will know, there are a lot of different data sources and very often you have to try and cobble together from a variety of them the best information that's available, including sometimes having to look to academics who have done reporting or work on various segments. So I wouldn't say it's part of the repository of information we have now, but on the going-forward basis, especially as we seek to try and make sure we know where the opportunities are for our new grads, this is the kind of information we're going to benefit from.

It's been one of the centrepieces of the work that Dr. Tepper is doing related to HealthForceOntario, to enhance our capacity, our data sets, because we're trying to work and resolve issues we know are problematic, but we're doing it very often with data that are forcing us to pull from too many different places. I think this really is an area where within a year or two we should be in a much improved circumstance, but I'm not sure we have very much on that at present.

Ms. Martel: Okay. If you could let me know one way or the other that it is or not, that would be great.

I wanted to ask, as well, about the numbers on the sheet. If I can go to Cancer Care Ontario, would those be nurses who are going into the regional cancer centres who are being hired that that's a reflection of?

Hon. Mr. Smitherman: What we've asked each and every one of our providers to do is, for the additional resources that they're provided with, to work back through their numbers and see what the hiring trend was. So yes, this is 53 additional nurses working in the regional cancer system as a result of increased resource provided to Cancer Care Ontario.

Ms. Martel: And the public health would be public health units, then?

Hon. Mr. Smitherman: Similarly, yes.

Ms. Martel: The infection control: Is that folks doing that work in hospitals or is that through public health units as well?

Hon. Mr. Smitherman: It could be either. I'm going by memory here, but I believe that this relates—as you may know, the ministry has had funding available to public health units for 180 positions, but they hadn't all

filled them. So the funding was available, but they hadn't filled them. I'm recalling here, so someone will tell me if I get this wrong, but I believe this is filling out those positions.

Ms. Martel: The smoke-free Ontario, I would assume, are public health unit positions, as well, over and above the inspectors to deal with responsibilities under the bill?

Hon. Mr. Smitherman: I don't know the answer to those six on smoke-free Ontario.

Ms. Martel: Maybe I can do it this way. Going down to Cancer Care Ontario and those five—

Hon. Mr. Smitherman: Sure.

Ms. Martel: I can see the notes going all over the place, so I'm trying to save you some time.

Hon. Mr. Smitherman: Mostly the notes are just telling me I was right.

Ms. Martel: Okay.

The Chair: Ms. Martel, what page are you on with the estimates for the—

Ms. Martel: No, I'm on the nursing sheet that was distributed yesterday. That's what I'm working with.

The last one would be mental health and addictions. I don't know if that's a reference back to the funding that was announced in May. I'm assuming it was an earlier period and those positions are now being filled.

Hon. Mr. Smitherman: Yes, and we would anticipate as we move forward that because additional resource has gone into that area, that would be added to the foreshadowing list, but yes, on those five, we'll get you a little bit more specific on each of them, as you've asked.

Ms. Martel: I know the hospital numbers have been in place. That was from the $50 million announcement some time ago. Do I assume, then, that people are in place in all of these positions, that this is a reflection of people now in those positions?

Hon. Mr. Smitherman: Yes, and if you look to the lower part of the chart, this is where we have funding out there and where we anticipate those numbers will be fulfilled, and we would only move them to the upper column once we have confirmation they have been filled.

Ms. Martel: One other thing on long-term care, and that has to do with money that is specifically going into the nursing envelope. The request I'm making is for the figures for the last three allocations the ministry has made on long-term care. I would like to know what the amount of money was that was invested into the nursing envelope specifically over those three announcements.

Hon. Mr. Smitherman: Okay. The deputy has noted it and we'll work to get that for you.

Ms. Martel: I wanted to ask about infection control. I was curious about who that was referencing, because there was a situation ONA has raised with the government that I'm not sure has been resolved yet, and so I wanted to raise it today. The question has to do with what, if any, are the ministry's requirements with respect to a single individual dealing with infection control in a long-term-care home. Is it a policy that there should be a single individual who is designated to do that? Is it more hit and miss? Can you tell me what, if any, requirement is in place with respect to who does what in that regard in a long-term-care home?

Hon. Mr. Smitherman: I have to defer to the deputy on that one.

Mr. Sapsford: I'll be corrected. I don't believe there's a specific individual. Infection control, of necessity, demands that the whole organization is focused on that. So there would be requirements for education, the standards that are involved, and generally it would devolve to the responsibility of the director of care to provide the leadership for that. Whether there are specific individuals charged with that full-time, I don't believe so, but I stand to be corrected.

Ms. Martel: Would it be a requirement for someone to be designated even if they have other responsibilities, so that in a specific home, someone would be responsible overall for those activities?

Mr. Sapsford: It's possible. Whether there's a ministry policy around that, I think, is more your question, and I can find out the answer to that.

Ms. Martel: What I'll do, then, is I'll leave with you a copy of the letter that I got from ONA. It's dated March 10 to Tim Burns. It was with respect to a particular home, the Chatham-Kent home for the aged. The letter that had come back from Mr. Burns said, "We note your statement that while the ministry doesn't require a full-time infection control incumbent, there must be a designated infection control practitioner."

In this particular home, the operator planned to have all the registered nursing staff share that responsibility, so of course ONA had some significant concerns that if someone was to be designated, it shouldn't be all the RN nursing staff. Someone should be designated and should deal with that responsibility. They wanted confirmation of what was the policy and could that be communicated to the regional office so this situation could then be cleared up in Chatham-Kent. I will leave you the correspondence we have, and if you can follow up with that, that would be very helpful.

I wanted to ask a question about the long-term-care website. This is the public reporting on long-term-care homes. The latest information, at least as of yesterday afternoon, for the current reporting period that's on the website is October 1, 2004, to September 30, 2005. I'm wondering what the time frame is within which the ministry updates this information for its homes.

Hon. Mr. Smitherman: I do know that when we launched this website at Mid-Toronto Community Services on Carlton Street, I'm quite sure that we spoke at that time to the expectation with respect to reporting. I do recall that the updating didn't seem as frequent as some people might have thought, and that was based on something to do with the way that the inspection reporting came out, but I'll need to get that clarified. So it does strike me as not the first time that I have heard that there's not that much cause for more frequent updating, but we'll try to clarify that answer for you.

1650

Ms. Martel: That would be the first question. The second would have to do with a commitment that was also made. It wasn't at the time that you launched the website; it was earlier, when you made an announcement on long-term care in 2004, the bigger announcement. When you had talked about the website going online, you had also said that, "Within a year we'll add to that a compliance record for every home, the number of violations in a home's most recent annual review, and staffing information, including number of staff per resident and their training." That commitment was made in May 2004. I don't see anything on this website yet that refers to that, so I'm wondering what the challenges are in having that information posted. Frankly, it would be good for the ministry, but it would be good for those who work in the homes to see that increased allocations are actually resulting in increased staffing. There's a whole accountability issue about having that information.

Hon. Mr. Smitherman: That's a great range of questions, and we'll get you an answer for them—

The Chair: Ms. Martel, I understand that the assistant deputy minister, Mary Kardos Burton, is here, if she can come forward.

Hon. Mr. Smitherman: That's not her area.

The Chair: Is she no longer in charge of that division?

Hon. Mr. Smitherman: John McKinley is, but he doesn't have the answer.

The Chair: He doesn't have the answer. Could you help the committee understand which budget the cost of this website comes out of?

Mr. Sapsford: It would probably be out of ministry administration, under long-term care.

The Chair: And you haven't cut back the costs of that budget?

Mr. Sapsford: I don't believe so.

Hon. Mr. Smitherman: No.

The Chair: You'll check on that for us?

Mr. Sapsford: For sure.

The Chair: Please proceed, Ms. Martel.

Ms. Martel: That information would be useful.

Hon. Mr. Smitherman: We'll get it for you.

Ms. Martel: I think it would be useful for everybody to see that the money is actually resulting in increased staffing, and the categories. So that would be helpful, thank you.

We touched a little bit yesterday on the long-term-care legislation. Without expecting you to go into details of what's in the package, I did want to raise the issue of whistle-blower protection. I know that was part of the consultation document and people were asked to respond to that particular provision. What I'd say here again is that I hope that such a provision will make its way into the legislation. I say that because there was a most recent example within the last two months of a personal support worker who works at St. Joseph's at Fleming in Peterborough who was disciplined for five days without pay because she made a comment to the media about her concerns about care in the home and them having to work too fast to do the best job they thought was possible. Of course, this has been taken on by the union, it's going to arbitration, but it has certainly sent a chill through the rest of the staff who work there about saying anything publicly. So I'm hoping that whistle-blower protection is going to make its way into the legislation to deal with employer reprisals just like this one.

Hon. Mr. Smitherman: The first thing, on the issue of the chill, the one thing we need to be a bit careful about is that—I remember the story, because I also remember reading a letter to the editor in the paper from several of the person's co-workers, having a different point of view. So it doesn't diminish it in any way—

Ms. Martel: There were two different ones.

Hon. Mr. Smitherman: I'm not sure—

Ms. Martel: Yes.

Hon. Mr. Smitherman: I'm not so sure about that. I can tell the honourable member that the legislation will come forward in the fall. It will be discussed; it will obviously be a priority for consideration in the Legislature at that time. But I believe that we well signalled our intention with respect to whistle-blower protection, and I have nothing to say today that is in contrast to what I've previously said.

Ms. Martel: There were two different stories, because there was an individual who had not worked at a home. In this case, she was still employed there and had suffered five days of discipline. So this is a worker who is still in the home and still trying to raise concerns about levels of care.

Also with respect to the long-term-care legislation, we had a discussion in the last set of estimates about the Casa Verde inquest and the many recommendations that were made that touched on responsibilities of the Ministry of Health, some very specific, that included, for example, that the ministry should fund specialized facilities to care for cognitively impaired residents exhibiting aggressive behaviour as an alternative to long-term-care facilities. Funding for these facilities should be based on a formula that accounts for the complex high-care needs of the residents in order that the facility be staffed by appropriate regulated health care professionals.

There was a second recommendation that the ministry should immediately mandate and fund these specialized units in sufficient numbers in each region to care for individuals with behavioural problems; that the ministry, in consultation with stakeholders, should revise the funding system presently in place for long-term-care facilities within the next fiscal year.

Another recommendation was that the ministry should do a follow-up; for example, to the 2001 PricewaterhouseCoopers study, to determine how residents in long-term-care homes were faring now with respect to the level of care.

There were a number of recommendations that specifically touched on Ministry of Health responsibilities, and I haven't seen a response yet from the ministry in this regard, even though the jury recom-

mendations and verdict came out in April 2005. I'm wondering, are these going to make their way into long-term-care legislation? Are you going to have a separate announcement, since it's been a long time already?

Hon. Mr. Smitherman: I can tell the honourable member that within the last few days we've responded directly to the coroner related to the Casa Verde recommendations. Of course, the ministry in that case would demonstrate those where we've moved forward or whether we have an alternate recommendation that can be implemented quickly. There are some which remain under consideration and some which we take a different point of view around. So that information has been provided.

I can tell the honourable member, just on the first question that was raised, obviously you spend time in long-term-care homes, just as I do, and we know there is a tremendous burden in long-term-care homes of people associated with dementias. Creating a separate system for people with dementias seems to me, frankly, to be a little bit odd. I do think that what we're looking for is the opportunity to appropriately address the challenges in long-term care related to dementia. One of the things we have initiated, consistent with the recommendations, is a $2.4-million training program we're involved in that we launched quite recently for front-line health care providers who are working with people with dementias—just as a small example from the top of my head in terms of what we've been able to move forward with.

Obviously there is more information contained in the response to the coroner's report, but just to let the honourable member know that on some of these, of course, we agree wholeheartedly and move forward quickly; on others we think there's a different system response that still allows us to address the underlying challenge, which we know to be strenuous, which is related to the number of people with dementias in long-term care.

We take those recommendations seriously. We're working our way through them, and we've responded to the coroner.

Ms. Martel: Is that a public document, the ministry's response? Can it be made public? Because there were a number of unions that intervened during that. ONA is one; SEIU is another. Both, in terms of these estimates, had asked me to ask where the response was.

Mr. Sapsford: I believe the coroner's office holds the process for making the document public, but I believe it is, yes.

Ms. Martel: Okay. The ministry's response has been tabled with them, so it's a question of us contacting the coroner's office.

Mr. Sapsford: That's correct.

Ms. Martel: Okay. Just to clarify again, Minister, you mentioned the $2.4 million, but we should expect to see some of the recommendations in the long-term-care legislation when it is released?

Hon. Mr. Smitherman: Yes. When you have 85 recommendations that we're working with, some of those are about policy and some of that is necessary to address otherwise. We had an opportunity to be influenced by the work of the Casa Verde inquest related to the development of the legislation, and as that comes forward in the fall, I think the honourable member will see that there.

Ms. Martel: I wanted to ask about Justice Cory's recommendations. You would probably have just received a letter, like I did—mine is a copy—from Irene Hsu. It was dated June 12, to you and then addressed to Mr. Kormos, myself and other members. It says, and I'm just going to put it on the record:

"I refer again to our previous correspondence, including your reply to my letter of May 9, 2005, and my subsequent request for a meeting with you to discuss my concerns.

"It seems to me that there has been sufficient time for the government to prepare a plan and draft legislation in order to incorporate the recommendations of Justice Cory. His report was very clear and straightforward. It should not be difficult for those responsible within your ministry to incorporate those recommendations into similarly clear and straightforward legislation.

"I would be grateful for your advice as to whether draft legislation is available for public review and comment, and I repeat my request for an opportunity to meet with you in order to discuss my concerns."

1700

That letter was sent on June 12. You will know that Justice Cory did extensive work with respect to the MRC, was very critical of the process that had been in place, and made a number of recommendations, I guess about 125, last April. Your release of April 22 said that the government would be responding by last summer, 2005. I don't know what the response is or where it is, but it has been a long time and I wonder if you can give me an explanation about where this is heading now.

Hon. Mr. Smitherman: Sure. I can tell you, firstly, that it's not my intention to meet with Ms. Hsu. Obviously, we took up our responsibilities working with the College of Physicians and Surgeons of Ontario and the Ontario Medical Association and we sought someone of Justice Cory's stature, recognizing the complexity of the issue. I think it's important to know that, through co-operation in the House, we did put in place an alternative protocol which really was designed to focus more of our attention towards proactive communication, understanding that some of the problems that arose were really about people not being appropriately apprised of how to use the billing number.

I can tell the honourable member that the recommendations are contained in a piece of legislation that will be coming before the House in the fall, and I would look forward to the honourable member's viewpoint at that time. I can tell her that, while there was not unanimity on every one of the recommendations that Justice Cory presented, we've worked really quite diligently with those key stakeholders I mentioned before. As I've said, you can anticipate that as the Legislature resumes this fall we would be bringing

forward a piece of legislation that contains the amendments along the lines of those proposed by Justice Cory.

Ms. Martel: And the stakeholders would have included CPSO and the OMA?

Hon. Mr. Smitherman: Yes, and the OMA primarily; if there were others, I'm not sure. But those are the two groups that of course are first and foremost.

Ms. Martel: So we should expect that this fall?

Hon. Mr. Smitherman: This fall, yes. We're going to be busy.

Ms. Martel: I wanted to ask about mental health, but I wanted to ask it in the context of consumer survivor initiatives. In the last round of estimates, we talked about a local situation and there was mention about $1 million that had been provided in consumer survivor initiatives that the ministry was going to give me some more specific information about. I don't think I got that. I apologize, Deputy, but I don't think that I did.

I wanted to raise it again because I had asked specifically about a situation in Sudbury because I had written in support of their request for funding in January 2005. They have received some funding because they are amalgamating with another group, but there is still an application to expand that remains outstanding that the deputy sent me a letter on in December, saying there would be some announcements soon. I may have missed something, but I don't think I did.

I'm wondering if you can give me some update on what is happening around generally consumer survivor initiatives, and if I can talk to someone more specifically about what the plans are for Sudbury, because this amalgamation of the two groups is going forward but there is an outstanding request for funding that hasn't been dealt with yet as far as I'm aware.

Hon. Mr. Smitherman: The Sudbury piece I'm going to have to defer on, but I can tell the honourable member largely on consumer survivor initiatives that I wish I had my fan mail handy. I don't get very much of it, but some of that that I do get is from people who are involved in consumer survivor initiatives. One thing that we've done is provided seed funding to one lead organization in each of our 14 local health integration networks; $30,000 a year to ask them to play a role in helping to coordinate all of the consumer survivor initiatives that might be ongoing in individual local health integration networks. We've also increased funding in percentage terms by enormous amounts for consumer survivor initiatives, and I think with a few more minutes we'd be able to give you a little bit more additional information along that line.

There is in the northeast—and I can't tell you, very honestly, whether it's a Sudbury issue, or maybe it was a North Bay issue, that is tied up in the issue of the northeast mental health alterations that we've made stemming from the Ken White report. So there's a lot going on up there; I can't remember all of it. But I'm quite certain that we'll be able to get you more information about that, and also to try to unlock the circumstances related to the Sudbury issue in particular.

Ms. Martel: Thank you. That would be helpful. If it's useful at all, they got seed money to work with a facilitator to bring the two groups together. That I saw and was given information about, and that process is under way. They have developed a new board. It is the original allocation and request for funding that has still never had a response to it. That would be very helpful.

How much time, Chair?

The Vice-Chair (Mr. Garfield Dunlop): You've got about five minutes.

Ms. Martel: I wanted to ask about what is happening with respect to federal and provincial ministers committing to treatment for both Fabry and MPS1, because I saw a most recent—June 13—press release put out on behalf of a number of groups that listed a number of concerns. I don't pretend to know the details of the agreement that was reached, so I would like some information about that and, Minister, your understanding about how the process is to unfold from here.

Hon. Mr. Smitherman: Just to speak very candidly, I was the co-chair of the FPT process last year and Ontario fashioned a solution which has largely been done and awaits only the confirmation of federal Treasury Board. If I'm saying things that I'm not supposed to say, that's just too bad; I do that all the time. I think, in the context of the final hours of the Nova Scotia election, the government of Nova Scotia or something like that might have sought to communicate that a deal had been made.

To be honest with you, we've been waiting for this new federal government for months and months to ratify an arrangement that had been concluded with three parties to it, if you will, broadly—the government of Canada, the governments of the provinces and territories, and the manufacturers—that would see products supplied to people associated with a research regime that would run for three years. The broad outlines of this deal are as I've just said. It's very significant. The PTs are ready to go and have been ready to go for months and months, and all that awaits now is final approval from the government of Canada. Our very best information is that that item is to go before federal Treasury Board on June 22, which, to the very best of the information we have, is the last hurdle not just to announcement; to actually rolling this program out to the benefit of, I think, approximately 200 Fabry sufferers in Canada.

Interjection.

Hon. Mr. Smitherman: One hundred? I'm sorry, it's 100, not 200.

Ms. Martel: I'm unclear as to how people apply, because I notice that there are regional centres and infusion sites. For Ontario, the regional contract is at Sick Kids, Dr. Joe Clark. How does this work for people who are trying to get into the program—once federal treasury provides some cash?

Mr. Sapsford: These are well-defined populations, and most of these patients are already in treatment arrangements with physicians, so it's relatively straightforward to link up the treatment centres with the research project.

Hon. Mr. Smitherman: Maybe a late-breaking update, compliments of someone else's BlackBerry—a press release from Ottawa:

"Health Minister Tony Clement announced today that the federal government will participate with provincial and territorial governments and two drug companies in a three-year study on Fabry disease treatments. As part of this study Canadian patients with Fabry disease, a rare genetic disorder caused by a deficiency of the enzyme alpha-galactosidase A, will gain access to enzyme replacement therapy. The disease is most prevalent in" Nova Scotia.

It seems that we're basically there. This has been long sought-after, of course.

The Vice-Chair: Thank you very much, Ms. Martel and Minister. I will now turn it over to the Liberals for the next 30 minutes.

1710

Mr. David Zimmer (Willowdale): I have two questions, Minister, one having to do with the IMG program, international medical graduates, and the second question dealing with nurses.

This past Monday, I and a number of other MPPs from all parties had an opportunity to attend with you, through the day but particularly at lunch, at noon hour, at the Four Seasons Hotel for a celebratory program for graduates or internationally trained medical people who are about to enter the IMG program. I have to say that it was my sense—and I think I said it to you at the breakfast meeting; I think there were about 400 people at the luncheon—that there was such an energy and a level of hope from these graduates who were attending the program. They were incredibly productive individuals. I had occasion to speak to many of them in the course of an hour and a half, and they were radiologists and surgeons and general practitioners and dermatologists and all of the specialties. My clear sense was that they were so anxious to make a productive contribution to their profession and to their new-found homeland here in Ontario. They were really looking forward to their collective offering to our families and our society and our health care program.

In going through the estimates, I suppose the IMG initiative is sort of woven in various places throughout the estimates and I wonder if you could take just a minute or two and pull it all together and give us a bird's-eye view of how this program is unfolding, where you expect it to be going and so on.

Hon. Mr. Smitherman: The deputy might provide us with some of the dollars. I'm going to talk about some other numbers. Firstly, one of the things I think was noteworthy about Monday for a lot of members who were there was that same enthusiasm that you speak about. I note that not many of us could make the claim that you did, which is that I think you knew three of the people who were there. In a previous life on the Immigration and Refugee Board, you'd had a chance to deal with three of those individuals.

Here's where we're at in Ontario with respect to IMGs. Firstly, just to acknowledge in a broad sweep that over 20%—probably closer to 25%—of all the doctors we have in practice in Ontario today are foreign-trained doctors. So it's important to dispel any myth that they have not been well utilized. Of course, we need and we've worked hard to take better and faster advantage of their skill set, but nevertheless there are IMGs—foreign-trained doctors—providing a tremendous amount of care already in Ontario.

Since our government came to office in 2003, these are the numbers that are relevant: 86 foreign-trained doctors have been minted and are now out in independent practice; 287 foreign-trained doctors—IMGs—are in current training and residency programs; and 217 more are joining in the next few months—a total of 590 foreign-trained doctors. There were 205 doctors present yesterday. Some of those are minted, out there in independent practice, some are in current residency and some are headed into it, but I think the important note is that we made a commitment when we came to office to more than double the number of spots for IMGs, from 90 to 200. In the first two years that we had the 200 on offer, we fell somewhat short, with numbers like, I think, 165 one year—I can't remember the other—but this year, through our efforts, we've actually overachieved and we've got 217 individuals for the 200 spots that we had. This will mean, I believe, a pressure that the deputy will have to do some work around, whereby it looks like at least a million additional dollars than what's in the estimates will be required to support the fact that we've overachieved on the number at 217. I believe our base funding for that initiative—maybe that was last year—was $39.5 million, and as I've said, some additional resources will be required.

Interjection.

Hon. Mr. Smitherman: That's this year's enhancement. So $39.5 million was last year's number, and a $5.9-million enhancement this year, and because we've overachieved, probably even some upward pressure yet on that number.

Mr. Zimmer: My second question is about the nursing profession. It seems to me here are the two bookends to the piece on nurses. In 1999, Doris Grinspun, who heads up the RNAO, said in the Toronto Star, "Thousands of registered nurses and registered practical nurses have been laid off. Nurses have left the profession, even left the country, and enrolment in nursing programs has declined."

Then we fast-forward ahead to just recently, in the Toronto Sun, where there was a quote from Doris Grinspun again. This is six, seven years later: "It's a clear indication that Premier McGuinty and Minister Smitherman are listening to nurses." So there are the two bookends.

Investment in nursing runs throughout the various lines in the estimates. Can you sort of pull all of that together? What do the estimates mean for the nurses, the public and health care in Ontario?

Hon. Mr. Smitherman: I think there are a few things that I might comment on. The first would be that when Doris Grinspun has something to say, it's hard not to hear it. We in Ontario enjoy some really tremendous leadership in the nursing unions and in the nursing associations, and we work with them as primary stakeholders and, more to the point, as partners.

Some of what we're proudest about are the investments that we've been able to make. When I arrived at the Ministry of Health—you hear a lot, and there are a lot of numbers out there—one of the numbers that I heard early on, and it stuck with me in a really serious way, was that at any one time in Ontario, something like 2,000 nurses are on disability. Obviously there are a variety of stresses there, but soft tissue injury was a primary source of that.

If we go to hospitals and indeed long-term-care homes today, we'll see the effect of more than $100 million worth of investment in more than 21,000 bed lifts. I have heard from very many nurses—and they're starting to achieve data that backs this up—that this has literally helped to take a lot of pressure off the backs of nurses, to try to prevent some of those injuries. Rob Devitt, the CEO of Toronto East General Hospital, will talk very proudly about how this has helped them eliminate some of their disability challenge. That's obviously measurable as a price, but it's more appropriately considered in terms of the implications on the actual physical health of our nurses.

We also provided hospitals with $11.6 million to help them convert to safer medical equipment, including safety-engineered needles. This has allowed a variety of hospitals in Ontario to implement those policies.

Then we've invested $33.7 million since taking office to give experienced nurses less physically challenging work; not really just for the purpose of giving them less physically challenging work, but taking their big brains and their passion and helping to transfer that on to our newer nurses. Some 1,700 nurses last year experienced the capacity, the chance, the opportunity to provide some additional support to the new nursing grads.

There are a few things that are relevant on the front with respect to new nursing grads: We provide quite a bit of resource to enhance the capacity of the faculties. As an example, we're doubling the number of nurse practitioner spots. That means the faculties need to be larger, and we provide support to make sure that the faculties have good quality nursing. I know that Sue Matthews, our chief nursing officer, is here. We were at work on a variety of points to implement the good ideas that come out of her shop.

Two others that we're really proud of—one that I had a chance to speak about yesterday is our new grad initiatives. I know one of the questions that was asked yesterday was about how many of the new nursing graduates who get a three- or six-month opportunity to learn the skills actually transition into full-time employment. I was told, since yesterday, that a number of more than 1,300 have experienced that. That's fantastic.

One of the other things we are really very proud of, which the Ontario Nurses' Association, sadly, and the third party have been critical of, is the investment our government has made over two years in nursing simulation equipment. I was at Northern College in Timmins two Fridays ago and had the chance to hear first hand again the enthusiasm of those young nurses who get the opportunity to practise in simulated environments. As any of us can imagine, it's a very daunting task to go from the academic environment into the clinical practice environment and all of a sudden start giving people needles and all of that. They used to practise on grapefruits and oranges, and now in Ontario they have the privilege of practising on very sophisticated simulation equipment. For instance, if an inappropriate dosage is given, a computer is able to analyze that and circumstances emerge that give further practice.

All of these things taken together are a reflection of the comprehensive nature of the resources and supports we've trying to provide, to address some of those underlying challenges that we know have been there for our nurses. We value them. We think of them as the heart and soul of health care. Accordingly, we have an obligation to keep them healthier and safer in the first place and to support them through their training in fashions that will make them all the more able when they are out there in the clinical setting.

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Mr. Jeff Leal (Peterborough): Thank you very much, Minister. I'm pleased you're with us today. I want to ask you questions specifically about long-term care. I spend a fair bit of time in long-term-care facilities in Peterborough, perhaps scouting out future accommodation down the road.

I'm looking at this section of estimates in long-term care and I see that when you compare this year's spending to the interim actuals from 2005-06, there's an increase of approximately $158 million this year. I understand that significant funding has been provided to increase the number of staff and nurses in long-term-care homes in the last three budgets. Can you give me some idea of the results of these new investments?

Hon. Mr. Smitherman: I'm going to let the deputy walk you through these. At the instigation of the Chair earlier, who suggested to me that rather than taking a formal break, I should find the opportunity to do so while the deputy was answering a question, I'm going to take my leave, however briefly.

Mr. Sapsford: I guess it's up to me, then, Mr. Chair. Yes, many of the investments over the course of the two-year period had to do with the expansion of new beds in the system—both new, licensed long-term-care beds as well as interim alternate-level-of-care beds. Some of the differences between the expenditures last year and the estimates for this year, however, relate to slowness in some of the uptake. So in last year's change from the estimate to the actual expenditure, there was an under-expenditure related to the implementation of some of the

alternate-level-of-care beds. That explains some of the variance in that number.

The second part of the variance relates to the policy of the ministry regarding occupancy levels. We pay on a per diem rate for beds that are occupied, and where the occupancy of a home falls below a certain level for any number of reasons, the ministry recovers the difference from the home as a savings to the estimates. That accounted for another large part of the variance between the estimate for last year and the year-end position.

Beyond that, for the current year, $42 million is being invested in wages in acuity-of-care levels based on the assessment of individual residents in the homes. Where the acuity of the level of care is increasing, additional funds are provided.

There is an additional offset. The government had decided previously to freeze the level of copayment to residents, and the ministry was offsetting that increase in the per diem directly to the long-term-care homes.

The third area of investment is in municipal tax offsets. That amounted to $33 million for the current year, where the ministry is paying for the municipal tax on behalf of the long-term-care homes.

Those are the major areas where additional investment has been provided in the current estimate.

Mr. Wilkinson: How much time do we have, Chair?

The Vice-Chair: Seventeen minutes.

Mr. Wilkinson: Minister, I just want to recall that when we first formed the government, we had our Commitment to the Future of Medicare Act, and I remember there were people criticizing us that somehow this plan—"Orwellian" was the term someone used—was going to undermine public health care. I distinctly remember that when there was a private interest that wanted to move into Ontario to provide services, many of my constituents got a hold of me, afraid that this would be the thin edge of the wedge for private health care, that people would be able to pay their way to the front of the line. I said, "Well, actually, we've done something about that: the commitment-to-medicare act," which enshrined medicare, a federal statute, into Ontario laws so that you, as the minister, and our government and subsequent governments would have the power to deal with these issues and not go cap in hand to the federal government, which at times seems to be wavering about the commitment to medicare, making sure that it is universally accessible to all.

I just wanted to ask you for your own feedback on the commitment-to-medicare act and whether or not you found it an appropriate tool to make sure that Ontario stays on the one-tier system.

Hon. Mr. Smitherman: I can say to the honourable member that there are least two different, unique circumstances where criticisms that were made of the Commitment to the Future of Medicare Act have actually been, I think, quite soundly repudiated. I note that this is a bill that did not enjoy support from all parties in the House; from one party, though, it did, and that was enough, thankfully. We've obviously seen circumstances where some of what was contained in that legislation did give us the capacity to stand down the threat from Lifeline, an Ohio-based company that was intending to come and offer on a proactive basis full-body scans and all of that, especially targeted to seniors and the like.

We have been very clear in using the principle that we're not going to stand idly by while health care services are aligned in a fashion that providers wish to bill the government of Ontario for the provision of a service that is only available to a person who has forked over large to get in the door in the first place. We're not going to countenance the idea that you have to pay a fee before you can access a publicly funded service, and we're going to use those penalties that are there, as appropriate.

Threats abound. In a health care environment, where there are obviously significant business interests aligned around it, the threats are very, very clear and our principles have remained very, very clear as well: We believe fundamentally in the public health care system in Ontario; we support the view Roy Romanow takes that accountability was the missing sixth principle, and that has been an important principle that we've advanced through health care. I believe, as a result, we can indicate that when we make investments in health care for a specific intent we get the desired result from it in a fashion that previous governments had more difficulty around.

The other part where I think the criticisms around the Commitment to the Future of Medicare Act have been repudiated was on the issue of the Ontario Health Quality Council. If you read back through Hansard then, you'll see a tremendous degree of cynicism about that. But when the Ontario Health Quality Council, which has now come to life, brought forward its first report, it highlighted many, many helpful areas where we can enhance equity in the Ontario health care system. The opposition parties said that it would be nothing but a toothless tiger and that the government would never allow it to actually offer a critique of the health care system. In fact, it has done that in exactly the fashion that we had anticipated.

So I think the Commitment to the Future of Medicare Act, as the first piece of legislation that I had the privilege to bring in, has proved to be very effective in advancing the health care system in Ontario and protecting it on the basis of the values that we bring, which we think are dramatically shaped and informed by the values of the people of Ontario.

Mr. Wilkinson: Further to that, just moving forward on the issue of accountability, I distinctly remember when you were bringing in legislation which some thought was very controversial, that we should have accountability agreements signed with our service providers, particularly our hospitals, so that again, this was some thin edge of the wedge, that we were going to use this so that we would not be funding hospitals. I remember having delegations from people. Can you just bring us up to date on the status of where we were in regard to percentages of hospitals that were routinely not

balancing their budgets, where we are today, what other challenges we have, and just your thoughts, your input and insight as to whether or not that has ended up being either good or bad public policy?

Hon. Mr. Smitherman: I think what I might do is give you some stats. I don't have all of the stats that you might have requested, but I think the deputy should offer some comment here too, because he has a very unique perspective now as the deputy, formerly as an assistant deputy minister, and of course in the time between he played a very senior role as a staff person in one of Ontario's largest and most important hospitals.

We have, at present, 140 of the 152 hospitals in Ontario that have signed their accountability agreements, which indicates that they have established an appropriate pathway to being in balance. I believe Peterborough is probably to be added to that list.

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This is a reflection, to my mind, of a few things: firstly, the principle of accountability, which I spoke to a second ago, the sheer necessity on the part of the taxpayer to actually know what you're supposed to get for the dollars that you're transferring, keeping in mind that we spend around $13 billion on our hospitals and that the lion's share of that is transferred as a global budget. It's not like it's envelope funding where we have precisely indicated what we're getting. As we've worked on the wait times agenda, of course, those new resources that we've put in have been clearly attached to an expected outcome.

I would just close by saying that's new. Any time there's something new it's challenging, and we have learned a lot of lessons as we've gone forward. I have watched the evolution especially of Ontario's hospitals in the last two and a half years in a way that makes me very proud. There are lots of challenges out there yet, and they have a hard bit of work to do, no doubt. But the cultural evolution that's gone on in the hospital sector in Ontario is, to me, something that those hospitals and the voluntary board governors who contribute an awful lot of their time and energy to helping to steer these big entities deserve a lot of credit for. We look forward, as local health integration networks come to life, to applying the principles and the lessons we've learned as we bring the issue of accountability agreements to a broader array of health care providers in the province of Ontario.

If you'd allow, though, I think the deputy's perspective on this would be very helpful.

Mr. Sapsford: The environment in terms of the relationship between the ministry and hospitals is very good, and that comes after many years of co-operative working relationships. I think, as the minister has indicated, with the legislative framework around accountability agreements the ministry and hospitals together have pursued a mechanism to put the legislation into operation, so that the current accountability agreements—the structure of them, the content of them, the process of the review, the submission process, how the ministry responds to them—have all been developed in a co-operative way with the hospital community.

Coupled with that is the three-year funding announcement, which hospitals for many, many years had asked for. The government responded by giving three-year projections of operating funds. That allows the hospitals a longer time to plan. It allows them to consider investments in their own operation, which allows for the potential to generate savings in operation in the future. Those kinds of initiatives that hospitals are now taking as a result of a more stable planning environment are allowing for better operating plans to be submitted as part of the accountability process. For the ministry, it's meant that in our relationship and dealings with hospitals we're able now to deal with hospitals perhaps on an exceptional basis. So rather than dealing with all 152 with issues, we're now able to deal with a smaller number, where there are very specific operating issues that we have to respond to in an individual way. So I think, all in all, we have a much better framework for working together to both plan for better hospital services and manage the very difficult fiscal environment in which they live.

Mr. Wilkinson: Thank you, Deputy Minister. How much time do we have, Mr. Dunlop?

The Vice-Chair: You've got about seven minutes left.

Mr. Wilkinson: I believe Ms. Mitchell has a question.

The Vice-Chair: Please, Ms. Mitchell, go ahead.

Mrs. Carol Mitchell (Huron–Bruce): Thank you. Certainly, Minister, I want to first of all thank you. I took the opportunity on Friday to make the announcement in all seven of my hospitals with regard to the multi-year funding. I can tell you that it was very well received in every one of my seven hospitals, and I might add it took me 12 hours to do it.

My question today is: What do you see as the role that our rural hospitals will play in providing health care throughout the province of Ontario?

Hon. Mr. Smitherman: Firstly, on the issue of multi-year funding, I think this is one of the smartest things we've done. It didn't cost us anything to be better organized, but I would argue that in the grand scheme of things it saves hundreds of millions of dollars. You want me to run a big organization and you want me to deliver it on budget and you're going to tell me six, seven, eight, 10 months into the year what my budget is? This doesn't work. We've really worked hard as a ministry—even in those instances where we haven't rolled out multi-year funding—to get our funding announcements up earlier into the year. Public health is probably one of those places where Dr. Basrur is working to try and turn things around. But as a principle, we just think that's sensible and important.

On the issue of small rural hospitals: Firstly, I'm very proud to be a Minister of Health who has never had to waiver on this point, which is that we are not going to close hospitals, not today and not tomorrow; it's not our plan. In many communities where people are fearful of alterations, I've had the chance to say, "Your hospital has a proud history and it has a bright future."

The issue of the future is where I want to focus my comments, because I've seen this angst out there. I think it's most prevalent in some of those smaller hospitals that are networking with larger ones. The threats seem a little prevalent in those instances. We're working very hard right now through the leadership that the ministry and the OHA are bringing together in a process that we call the JPPC—I think that's the joint policy and planning committee—to develop the capacity to be able to say to every small hospital, "These core services, this foundation, this base is a range of services below which you should never expect your hospital to go"—that is, at least to establish the foundation of what services should be there. We're not there yet and we have more work to do. But we have done some alterations in the funding that we've provided to smaller hospitals, even in those that are in network circumstances, to make sure that when we flow dollars that are intended for each and every site, they don't all get intercepted, if you will, at the biggest site in the network. So I would say that we've established our principle.

I figure that if we eliminated small hospitals, the effect would be obvious in terms of the implications for patients and for a lot of those smaller communities where these are very, very important for the whole fabric of the community. But even from a systems standpoint—I feel quite strong on this point—if we didn't have those smaller hospitals playing that role, especially because they're very often quite ingrained in the provision of primary care, I think it would put pressure on larger hospitals, where we've experienced some of our greatest challenges in unlocking their capacity to operate in a balanced way. If you don't have the smaller hospitals out there as screens, if you will, providing care closer to home, then people have to travel further, which is no good for anybody, and those larger hospitals very often struggle to provide services in a timely way and in a way that is economically sustainable. So I think the future of small hospitals in Ontario is secure, and with the policy work we have under way, we'll be able to make that point even more forcefully as we go forward.

Mrs. Mitchell: Thank you, Minister.

The Vice-Chair: You've got about three minutes, Mrs. Mitchell, or anyone in the Liberal caucus.

Mr. Wilkinson: I think Mr. McNeely has a question.

The Vice-Chair: Mr. McNeely, if you have a question, you've got about three minutes total and then we'll turn it over.

Mr. Phil McNeely (Ottawa–Orléans): One of the things that I was very aware of when I first got elected and started talking to people in Ottawa–Orléans and Ottawa was that the wait times in Ottawa were probably the worst in the province. We had the ICES report from, I think, May 2005. We put together 14 of the procedures and the wait times for those, and we came out the worst in the province. I think that was evident. I asked questions around, and they said, "Well, that's because of Quebec." I guess there was a lot Quebec funding in the Ottawa area back in the 1990s, and we never did catch up.

One thing I must say is that even if the wait times were terrible then, they've changed drastically. I get new information from people. I do not get the calls at the office any more. The first year, it was a steady stream of calls on wait times and not being able to see the specialist. I think even though the wait times were long, there were even other wait times for specialists. The specialists just weren't dealing with people because they just couldn't get them into the lineup. So there have been changes.

I would just like to say that I'm pleased about the way things are going now in the Ottawa area. I would just like to have your comments about what the situation is now compared to what it was in 2003.

Hon. Mr. Smitherman: I remember very early on that you made these points forcefully, and we learned a lot of lessons. When I roll around Ontario, I talk a lot about—I don't understand how Ottawa, as an example on MRI, which is to me the most pressing one, was such a forgotten zone. I think that we've worked very hard. The local health integration networks provide the platform for us to measure in a consistent way and therefore to make funding allocations on the basis of producing an equitable result. We will enhance our capacity to do so as we go forward, by bringing into consideration the underlying population health in each of those local health integration networks.

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In northwestern Ontario, they have a large First Nations population. That influences the necessity of health care there, because the underlying population base of First Nations is very, very challenged. We need to do a better job on that basis, and we have only begun now to do that.

But here are the results that we've produced in the Champlain LHIN: MRI wait times have gone down 80%; CT scan wait times have gone down 4.9%; knee replacement waits down 5.8%; cataract surgery waits down 9%; bypass surgery waits down 33%; angioplasty down 46%; angiography down 20%; cancer surgery waits down 7%. None of us pretends that this is every service in health care, but we are learning lessons in each and every one of these that are being applied in other elements of the health care system. We're enhancing our understanding of what it takes to flow through our surgical suites better, to use other health care providers to enhance the overall capacity.

We still have challenges in the Champlain LHIN. I'll give you one example: We do not have as much hip and knee capacity as we'd like to address all of the challenges there. The deputy and Hugh MacLeod and others have been working with them in Ottawa, in Champlain, to unlock some solutions which will allow us even further to enhance the capacity to address some of the underlying challenges, including on hips and knees, which is one area where we still need to do quite a lot better for the folks in the Champlain LHIN. But I think Ottawa is one

of the places we can point to with pride where we've not just produced better results but are producing more equitable results.

I just fundamentally believe that if you're going to have a public health care system, then you have an obligation to look at an equitable result. It bothers me that we allowed year-long waits for MRI in Barrie while in downtown Toronto some hospitals had waits of three, four and five weeks. The good news is that in Barrie now we've got those wait times down to a much more manageable number, and a new MRI that's going to come to life in Orillia that's going to give that LHIN a much better result than the one that they were experiencing so far.

The Vice-Chair: Thanks very much, Minister.

Mr. McNeely: Do I have another question?

The Vice-Chair: We're out of time with you folks now. I'll turn it over to Mr. Jackson to finish up the last 20 minutes today.

Mr. Cameron Jackson (Burlington): Minister, much has been stated about your capital plan. I wonder if we could get a clearer explanation of what the capital commitment is in the hospital area each year. In my area of the province we've got commitments in five years from now. I've seen several numbers; they're large numbers. Is it possible to get what will be approved this year, what will commence in year 2, year 3, year 4 and year 5? Is that possible?

Hon. Mr. Smitherman: I believe this is essentially a repeat of the request made yesterday by your health critic and—

Mr. Jackson: The second part of that question then would be, are we to assume that if you don't have an approval in those first five years, we're looking at year 6 for anything that's not been approved to date?

Hon. Mr. Smitherman: In a certain sense, never think of it as a year 6, but that each year that you move into you add another—so it's a rolling five-year plan.

Mr. Jackson: I get that. I'm just asking—you have several applications in front of you now in various parts of the province—is it safe to assume, or is it clear, that those capital projects would have to occur in the out years as opposed to something you'd bring forward to approve in year 1, 2, 3 or 4 of your plan?

Hon. Mr. Smitherman: It's very difficult. It would be safe to assume, it would be reasonable to assume that if you do not have at present a slot in the five-year plan, looking towards the end of that at the earliest is the most prudent approach. Having said that, it depends quite a lot on the scale of the project. We've worked very, very vigorously with our colleagues at the Ministry of Public Infrastructure Renewal to try and slot projects that aren't slotted. An example would be—

Mr. Jackson: Fair enough. I appreciate the clarity of the answer you're providing. So there are some smaller projects and some larger projects. There are two in Halton region that both my colleagues Mr. Flynn and Mr. Chudleigh have expressed an interest and a concern in, and to a degree, Mr. McMeekin: the application from Joseph Brant Memorial Hospital and the one from the Halton health sciences, which now embraces Oakville, Milton and Georgetown, and I believe they have a Milton expansion request in.

Can you share with me at this point an update on both of those applications, Minister?

Hon. Mr. Smitherman: Yes. I'm going to have to add years because I don't have those on my chart. I can tell you that the main rebuild at the Halton health services is a greenfield site proposal. This is for a new hospital in Oakville. I can tell you further, just while we're on the subject, that—

Mr. Jackson: I'm sorry to interrupt you. I'm familiar with that. I specifically asked you—

Hon. Mr. Smitherman: You asked me about two, so—

Mr. Jackson: —about Milton and Joe Brant. I didn't think the greenfield was classed as the Milton. Is that what you're suggesting?

Hon. Mr. Smitherman: No, I said Oakville.

Mr. Jackson: Okay. I didn't ask about Oakville. I'm aware of that. In the short time I have, I was hoping to pose the question about Milton and about—as you know, John Oliver is responsible for the three sites now.

Hon. Mr. Smitherman: Yes.

Mr. Jackson: That includes the Milton expansion. That's really what my question was about.

Hon. Mr. Smitherman: Yes. That project is moving forward in the five-year plan, and will benefit to the tune of about $2 million from the increase in ministry cost-share on construction.

Mr. Jackson: It has not been approved.

Hon. Mr. Smitherman: It is in the five-year plan, yes, the Milton project.

Mr. Jackson: So it has actually been approved?

Hon. Mr. Smitherman: Yes. I believe that's the maternal-child. Am I right about this? No, I'm wrong. We're getting a note. I'm sorry, the maternal-child unit at the Oakville site was included in the five-year plan.

Mr. Jackson: Yes. So my understanding, in conversation with both hospitals, is that neither of those has been approved, that they are still in your ministry. Perhaps you could you get back to me next week with a more fulsome—

Hon. Mr. Smitherman: Sure. Now you're talking about the Milton one and the Joseph Brant one?

Mr. Jackson: They're the only two I've raised.

Hon. Mr. Smitherman: Yes.

Mr. Jackson: Thank you very much. Minister, could you tell me where the current Alzheimer's strategy is in the estimates book?

Hon. Mr. Smitherman: I don't believe there is a funding line particular for an Alzheimer's strategy. I may be wrong about that. We have—

Mr. Jackson: Then could I ask which line it's buried in? Someone in finance?

Interjection.

Mr. Jackson: While they're assembling that, my question generally, minister, is with respect to if the

government can account for years 6, 7 and 8 of the Alzheimer's strategy, if it was continued or funded or if you're maintaining the strategy. It's really just a general question. I have a certain sense of ownership to the program, and I have been contacted by the Alzheimer Association to raise that question. Maybe I could get some response to that.

Hon. Mr. Smitherman: It's in the community support line.

Mr. Jackson: Thank you. It's in community support. So if we could have a detailed costing of that, it would be very much appreciated. Thank you very much.

Hon. Mr. Smitherman: Duly noted.

Mr. Jackson: Minister, you have made some changes to OHIP insurance services in the last year and a half. I have written to you, and this family has written to you on a couple of occasions—Andrea and Frank Stegne. They are seeking reinstatement of support for infertility procedures that can assist those couples. Is there any hope that you're reviewing that? Is there a limited process that you might entertain?

Hon. Mr. Smitherman: It's not a matter that's under review.

Mr. Jackson: Okay. I have a letter from the Premier saying, "I'll refer it. I'm sensitive to it. I'm referring it to the minister for his review and examination." So I can report back to that family that it's not on the radar screen for your ministry at this time?

Hon. Mr. Smitherman: It's on our radar screen. We get a lot of correspondence on it, but it is not a matter under review or reconsideration.

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Mr. Jackson: Okay. Next, I want to ask you about the cancer drugs, Minister. At the outset, let me begin by saying that we would like request the presence of Helen Stevens to be here for estimates next Tuesday to address a couple of issues on the drug line on page 245—

Hon. Mr. Smitherman: That's not her name.

Mr. Jackson: I'm sorry; help me out.

Hon. Mr. Smitherman: Stevenson.

Mr. Jackson: Thank you very much. We would like to formally request her attendance next Tuesday.

Hon. Mr. Smitherman: We will make officials available to address questions that you have about drugs, whether it's her or someone else, but we will certainly do that.

Mr. Jackson: All right. We would request Terry Sullivan as well, then, from Cancer Care Ontario as an agency.

Hon. Mr. Smitherman: I'm not sure that's in our purview.

Mr. Jackson: You don't fund Cancer Care Ontario?

Hon. Mr. Smitherman: I didn't say we didn't fund them.

Mr. Jackson: Okay.

Hon. Mr. Smitherman: We fund hospitals. We're not calling them. I'm just not sure about the—

Mr. Jackson: It's a scheduled agency. It therefore falls within—

Hon. Mr. Smitherman: I'm very familiar with what Cancer Care Ontario is, sir.

Mr. Jackson: You did say you were uncertain they could be impelled, and I was just indicating they're a scheduled agency, unlike a hospital. I was just helping you with your clarification.

However, Minister, I also want to ask if we could have a more detailed multi-year number with respect to colorectal cancer screening over the past few years. It appears on page 249. It's not a comparator. It's under the revised book format. It's hard for us to get a sense of that.

Hon. Mr. Smitherman: Sure.

Mr. Jackson: I want to raise the issue, and I want to set aside my own personal bias on cancer drugs. As the minister is painfully aware, I've raised this on many occasions in the House. My mother has just recently been diagnosed with colorectal cancer and so the work I've been doing in this area now has become far more imminent in my life.

I want to ask what your plans are for access to colorectal cancer screening. I now have 19 colorectal cancer patients in my riding alone whom I've contacted and spoken with. A disturbing number of these are women, and a disturbing number of them are under the age of 40. Therefore, on colorectal screening, I'd like to know what the real protocols are in this province for that, because most of them say that unless they're older, they're not being given access to the procedure. So it's not an accusation; it's a statement. I would like to get some information on that so that we can look at that a lot more. I have a case of a lady who tried to get a colonoscopy for a couple of years, and as soon as she got one was diagnosed with stage 4.

Now it's no secret, Minister, that the drug they're seeking is Avastin. This has been under review and recently our province determined that we would not be proceeding to cover this. As Wendy Mundell said to me last night, "You know, Cam, I've got the wrong cancer at the wrong age in the wrong province." If she was living in Quebec or British Columbia, she would be getting the treatment. She is now paying $1,500 per month at the Juravinski Cancer Centre in order to gain access. Suzanne Aucoin, whom I've raised in the House on many occasions, is now getting a portion of her treatment paid for by the province of Ontario in a Buffalo clinic, and the other portion of it, her Avastin component, she is paying for at the Juravinski centre.

Minister, my first request for information is, could you update us on what is the average cost of life per year benchmark that is being used for these cancer drugs in our province and, to the deputy, are we aware that that value per life per year per treatment is different in other provinces and, in particular—I suspect that Avastin was approved for a variety of reasons, but the question I'm raising is on behalf of those cancer patients who are saying, why did one province make the assessment that the average cost of a life per year gained with this treatment is so different between Ontario and Quebec?

Minister, I also would like to get an update on the drug that you and I locked horns over for I believe it was a record 12 questions on the floor of the Legislature, to deal with non-Hodgkin's lymphoma, and the drug I believe was Rituximab. I wondered if we could get an update about the additional $10 million, which we deeply appreciated you and your Premier approving, so that we no longer had an age threshold in this province for eligibility for that. I was pleased when the oncologists agreed to that.

Finally, with the short time we have left, the other clear message I'm getting from cancer patients is that fortunately, because they were younger, they were able to surf the Internet and find out about the availability of these drugs. Their concern to me was, "Cam, why is it that my oncologist refuses to, or feels uncomfortable, or feels it isn't their responsibility to inform me, as a patient in Ontario, that these treatments are available?"

That is a rather subjective question and I'm not sending it to you in an accusatory tone at all. I'm actually asking you as a Minister of Health how you feel about that decision by Cancer Care Ontario not to share that information or not to openly state it. We do have oncologists who are referring these patients to treatments. They are recommending those treatments. They come in the form of section 8, they come in the form of letters to all MPPs in this room. Somehow it strikes me odd that we're not letting some of these families—and you did make a statement earlier to a question from Mr. McNeely, "We're not going to countenance paying a fee for an insured service." But clearly for cancer patients, there are those who can afford to fundraise and to mortgage their home or to go to a family that has money and they have enhanced life chances as a result of access to those medications here in Ontario, versus those who may not even know or who have no capacity.

Again, I'm not discussing the issue of whether you approve it or not; I'm really asking you why our oncologists aren't helping them to better understand how to enhance their life chances, whether the case that's on the website is a person who served in the military, who was able to move to Quebec immediately and go on the treatment. If we could get information in response to those for next Tuesday, it would be very much appreciated.

The Vice-Chair: We're down to about three minutes left, Mr. Jackson, just so you know.

Hon. Mr. Smitherman: I would say there's a lot there. We will seek to provide as much information on point as we can for the honourable member.

I would talk in my three minutes about our intentions with respect to the colorectal screening program. I had a chance to speak about it yesterday. The reality is that of course we do see a tremendous opportunity. Cancer Care Ontario has focused on this as a priority, to develop a colorectal screening program for Ontario. We're committed to it. We're committed to moving it forward this year, to doing it in a fashion that seeks to target high-risk groups first. We've already included in our OMA agreement an incentive for doctors to be involved in screening appropriate individuals.

On a slightly longer-term basis, as we ramp the program up, it's going to be necessary to increase our capacity in a variety of health human resources in order to be able to have a program. We still have more work to do, very bluntly, on the details associated with the program in a fashion that seeks to address the underlying principle of equitable access. We did talk about that a little bit more yesterday and I won't push any further on that.

I'm not sure, Deputy, on the wide range of issues that was raised, if there's anything you want to put on the record.

Mr. Sapsford: Just on the colorectal screening, you mentioned the age issue. The evidence currently for formal screening programs for the mode that they want to use—the test—is most effective over the age of 55. So the formal screening program that we're looking at will be age-adjusted. But that doesn't stand in the way of people receiving the tests that are being talked about in a diagnostic sense. Any physician can order the tests that would be used in this more formal screening program, where individual patients present either with symptoms or with a particular history or background. There's nothing that bars people from getting the test today as part of routine care and treatment. The difference here is that the screening program does the test for every member of the population who fills that general criteria, and that's the difference between what is a diagnostic process versus what's a formal screen.

Mr. Jackson: Are we not also talking about the difference between a colonoscopy, considered one of the best forms of screening—it is deemed age-appropriate.

Mr. Sapsford: For diagnosis. I draw the distinction between a test for the diagnosis versus, "We're going to do the test whether we think you have it or not," which is a screening procedure. The first test for this screening is a fecal occult blood test, which is the principal screen. But anyone can have that test if ordered by a physician.

The Vice-Chair: Thank you very much, everyone. This concludes estimates for today. We'll adjourn the meeting until Tuesday, June 20, at 3:30 or following the routine proceedings of the day. Thank you, everyone, for attending. We'll be in room 151 next week, on Tuesday.

The committee adjourned at 1800.

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