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Mardi 20 juin 2006

Standing committee on estimates

Ministry of Health
and Long-Term Care

Comité permanent des budgets des dépenses

Ministère de la Santé
et des Soins de longue durée

Chair: Cameron Jackson
Clerk: Katch Koch

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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON ESTIMATES

COMITÉ PERMANENT DES BUDGETS DES DÉPENSES

Tuesday 20 June 2006

Mardi 20 juin 2006

The committee met at 1600 in room 151.

MINISTRY OF HEALTH AND LONG-TERM CARE

The Chair (Mr. Cameron Jackson): I call to order the standing committee on estimates. We have approximately two hours and 50 minutes remaining for the Ministry of Health and Long-Term Care. Let me begin by asking the deputy and the minister, do you have any of the responses that—they've been tabled and presented? We appreciate that very, very much. Thank you for that. Were there any questions or clarifications you wanted to provide to those questions at this time?

Mr. Ron Sapsford: There was only one detail. I think Ms. Martel had asked for a nursing breakdown by RNs and RPNs in long-term-care facilities. We're still working on that part of it, although we've tabled today the net numbers to her questions. We'll be able to table the detail, I hope, by tomorrow.

The Chair: Thank you.

I believe, Ms. Witmer, you have six minutes remaining in your rotation, if you'd like to begin.

Mrs. Elizabeth Witmer (Kitchener–Waterloo): I want to just ask some question on the IMGs. Of the 200 IMG positions you spoke of last Wednesday in committee, how many of those were filled by those who studied abroad and have come back to Canada—in other words, people like the Irish grads—and how many are IMGs who have trained and perhaps also practised in other countries?

Hon. George Smitherman (Minister of Health and Long-Term Care): As you know, we've worked to create capacity for the IMGs who train abroad to hit the later CaRMS matches. So as a result, we oversubscribed for this year—as you know, this is something that we tried to do last year. We were too late in the game, so it's only really been possible this year. Going from memory here, but they'll correct me if I'm wrong, we have 200 spots but we've oversubscribed, which I mentioned, with 217 in total. Of the 217, 35 are from kind of the "Ireland and other" contingent, Ontarians who have gone abroad for their medical education.

Mrs. Witmer: How many people took part in the IMG technical examination this year, and how many went on to participate in the practical exam?

Hon. Mr. Smitherman: We'll get you those numbers.

Mrs. Witmer: Okay. I'm going to turn then to another area—

Hon. Mr. Smitherman: Sorry. I can tell you—there were two questions. There was a question about a written exam and—

Mrs. Witmer: The first was the tech exam and the second was the practical.

Hon. Mr. Smitherman: They all do both, and it was a total of 917.

Mrs. Witmer: All right. Taking a look at some of the issues related to physicians—and you mentioned the CaRMS—are the IMGs, just for confirmation, going to be taking part in the second iteration of the CaRMS match in 2006-07?

Mr. Sapsford: In 2006-07, yes. The match is applied twice. There is a discussion going on nationally for next year about whether Canadian grads and internationally trained graduates will be in the same match or whether they will be running parallel. The Canadian association, the group that runs the match, is looking at a variety of options. We've taken the position that we would put additional positions into the pool, so that as more graduates are taken into postgraduate training positions there are enough positions put forward so that all people would receive placement. Whether they get it on their first or their second match is really the concern that's been expressed from some quarters.

Mrs. Witmer: The question is based on the fact that letting these IMGs into the second round of CaRMS was kind of a one-time deal. You're now saying they're going to do this in the second iteration as well. Is this a new policy, then?

Mr. Sapsford: As the minister has stated, yes. In Ontario what we've tried to do is to provide permanent positions. So as we've accepted more IMGs into the programming, we've placed new postgraduate training positions so that the universities can pick up the additional positions.

Hon. Mr. Smitherman: Because the match is so tight that the ratios are almost one to one, we've seen some of the frustration expressed by some students who don't get anywhere near their preferred choices. You can't necessarily give everyone their absolute first choice, but we do think it would be sensible to create a little more flexibility. That's been necessary. Obviously, this year we overachieved our 200 number, and that's good news for patients, eventually. So that's what we have in mind.

The deputy has mentioned that there's policy work ongoing. I think if we were to say it very directly, other provinces, typically, for reasons that I'm not 100% clear on, like to keep the CaRMS match very tight. I think it puts us at risk of maximizing our opportunities, and we'd like to look for the opportunities to have a slightly better ratio.

Mrs. Witmer: Although I think we all agree there's a need for access for the international medical graduates, there were a lot of concerns from our own Ontario medical graduates this year who were very worried that they weren't going to be accommodated because they didn't see this increase in residency spots here in the province. We got a lot of letters, which I know you've heard about as well.

Hon. Mr. Smitherman: I don't know how many letters you got. I'm aware of a good number.

Mrs. Witmer: Do you know what? I will tell you, I probably heard from almost every student. I mean, there were a lot of letters.

Hon. Mr. Smitherman: Well, a very select number of cases came forward, and in each instance, Dr. Joshua Tepper, our assistant deputy minister, dealt with them on a personal basis. The view we're taking is that we're going to be involved, if I can use the expression, in a fight to try to provide the right opportunity for every prospective doctor who's out there. That's the attitude that we've taken. In one case, I know that the desire was for a plastic surgery specialty, and that had been subscribed within the system's needs. We're obviously not going to be able to nail every one of those, but we are really seeking, on a case-by-case basis, to make the current situation work. And Dr. Tepper has been personally quite involved on a number of those, case by case.

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

Ms. Shelley Martel (Nickel Belt): I want to thank the ministry staff and the minister for providing us with some of the answers that we had requested, and we look forward to receiving the balance. Deputy, you and I had a discussion before we started about a particular letter that had gone from the Ontario Nurses' Association to the ministry, expressing a concern about whether or not a particular person or position would be designated with respect to infection control. I wonder if you just want to put that answer on the record.

Mr. Sapsford: Yes. We've provided a written answer in terms of the ministry's policy. And we've specifically done follow-up with the home that was raised in your question and have confirmed that in fact the nursing home has appointed a registered nurse as the infection control lead, so the substance of the question and concern that was raised has been addressed.

Ms. Martel: Great. Thank you very much.

My next set of questions has to with PET scans. I raise this in the context of two situations in my riding where, within two weeks of each other, two individuals were both told they had colon cancer, that it was inoperable and that essentially they should go home and get their affairs in order. One of the constituents went to the Mayo Clinic and paid privately to get a PET scan; the other paid privately in Ontario. In both cases, the scans clearly showed that they had single sites of operable disease. The operations occurred; they were successful; they are alive and well today, and they are in remission. So as a result of understanding that they had to pay elsewhere to get a diagnostic tool that clearly showed that they were not dying and that surgery was going to keep them well, I did an FOI request to the ministry and I want to ask some questions about that.

The FOI request came back in about February. There are a number of questions. The first is that I was looking at what the enrolment was in the trials that are going on now. There are five clinical trials; there's a registry. The numbers that I had as of January 31, 2006, had 508 patients registered in the trials. I wondered, because now we're in mid-June, if you can get or if we have an update on the numbers now involved in the trials.

Mr. Sapsford: Certainly we can provide the number.

Ms. Martel: What I'd like to ask then is, based on where we are, which was quite a late start to people getting into the trials, for a number of reasons, does the ministry have any idea when we would get to the position of having the capacity to deal with 1,500 PET scans a year? Because it was my understanding that this was part of the capacity that we were looking for, I assume, to make some kind of decision on whether or not PETs should be funded as an insured service.

Mr. Sapsford: The approach that the ministry has been taking is that there was a designed clinical trial, that patients were being moved according to the site of the disease, severity, the different clinical criteria, and were moving through the trial. There was a certain volume, I believe, for each section of the trial in order to come to some conclusions. Some of them have been satisfied—different sites, different diseases—and in fact in a couple of cases the ministry has decided to move forward and fund PET scanning for very specific procedures in certain diseases. But I can find the information in terms of updating the volumes on the arms of the trial and how long we anticipate it will take to find that number of patients to put through.

Ms. Martel: The information that I had in February had a target enrolment for each of the clinical trials and a target enrolment for the registry. At that point, none of the enrolment was near the targets, so my next question would be, although you have said that the ministry has made some decisions, I'm not clear, then, which of the five clinical trials has moved to a point where you are actually going to fund this through OHIP, and is that the case? Because my second understanding was that there was also a time frame, a period over which the trials had to continue before the ministry would be in a position—and I thought it was a two-year time frame, and we haven't reached that yet for any of the trials, because the first one really only started in May 2005. So can you clarify what is the time frame by which the ministry

would look at the results and then start to make some decisions?

1610

Mr. Sapsford: I'll clarify that. My understanding is the two years, though, is to some extent based on an estimate of how long it would take to find that number of patients who would qualify, but I'll clarify that as part of the response.

Ms. Martel: Because that would then impact on when a final decision could be made about funding this as an insured service or not.

Mr. Sapsford: Correct.

Ms. Martel: I wanted to ask, then, if you could give me an idea of what the cost of an individual scan is.

Mr. Sapsford: We'll get that.

Ms. Martel: Then let me ask some more questions. I wanted to know whether or not that cost per scan is the same for those involved in the registry as for those who are involved in the trials going on in the hospital. I'm not clear on the difference between what's happening with those who are involved in scanning for the registry and those who are involved in the five hospitals. I would like to know if the cost per scan is the same.

Mr. Sapsford: I'll find the information. I would suspect that the costs that the ministry is paying for in the trial are different, between the two, because in the case of the trial, the hospitals involved that have the machines are bearing some portion of the cost on their own. So if your question is total cost, that might take longer. If it is how much the ministry is paying, costs against the trial, that would be a simpler approach.

Ms. Martel: It would be the second, because on the sheet that I was given, with respect to the hospitals, the Ministry of Health funding amount for each hospital for each trial was provided. What wasn't provided was the funds committed by the hospital. It did say that it varied by hospital, but there are question marks beside every single one.

My next question was whether or not the hospitals continue to be in a position to find their share with respect to whatever portion—50%, 40%; I don't know what the percentage is and if it varies—to have that, to ensure that the trials will not be underfunded; that there are sufficient funds between the ministry and between the hospitals to ensure that the entire cohort that you're hoping for will actually be able to—

Mr. Sapsford: I'm not aware of any hospital that has dropped out, but I'll certainly check that. If they're still in, then I would assume that their costs they've agreed to put forward as part of the trial are still there. I'll check that.

Ms. Martel: If I could get the funding per hospital, that would be great. The ministry's funding appears to be $130,000 for each, from the information I have.

The other question I had was the funding: Except for money that went to UHN in 2005-06, the rest of the funding originated in the year 2001-02. I'm assuming that most of it wasn't spent, because the first trial only seemed to get up and running as of May or March 2005, so it's not clear to me if the ministry is allocating additional funding now or if that $130,000 reflects money that has essentially been held until such time as the trials can get up and running. The only recent allocation seems to be 2005-06 to UHN.

Mr. Sapsford: It may have been that the cash was flowed in that year, held by the hospitals and then applied to the trial as the patients went through. I'll check that.

Ms. Martel: Also in the briefing note it said that the ministry was in the process of reviewing or extending the research studies because the agreements between some of the hospitals and the ministry had expired. I would like to know now if all of the agreements between the hospitals that are involved in the trials have now been renewed and signed off, and whether or not that also results in any additional funding.

Mr. Sapsford: Okay.

Ms. Martel: But you did clarify that some hospitals in particular are paying some portion, and we just need to know what that is.

Mr. Sapsford: Yes.

Ms. Martel: I had some concerns with respect to what else was in the briefing note. The briefing note said that Ontario's position—that is, how the clinical trials were established—"is strongly endorsed by leading PET scanning experts in the UK." That's a quote from the briefing note. But I wanted to read into the record concerns that had been raised by nuclear medicine experts in Ontario with the head of ICES. This goes back to September 28, 2004. It was a letter from Christopher O'Brien to the head of ICES. I gather the head of ICES still sits on the PET steering committee, so it would have been relevant to send it to him. Dr. O'Brien is the chair of the OMA section on nuclear medicine. I raise this as a contradiction, I guess, to the ministry statement that, "Our approach on the trials was strongly endorsed by experts in the UK."

He said, "A recent draft position paper from England stated, 'The evidence of benefit from PET scanning is now sufficiently robust to support the establishment of facilities across the country so that all appropriate patients can have access to this technology.'

"Within this draft document, it is also stated, 'Within cancer, the evidence of benefit for PET is strongest for patients with lung cancer, lymphoma and colorectal cancer.'

"The draft document continues further to state, 'The first consultation on the revised NICE guideline for the diagnosis and treatment of lung cancer finished on July 13, 2004. One of its 10 key draft recommendations is that every cancer network must have rapid access to PET scanning for staging disease.'

"Furthermore, the document states that the provision of PET facilities in the UK compares unfavourably with that of most other western European countries where PET is now an accepted technology for the management of patients with cancer."

I raise that because I would be interested to know what specialists in the UK the ministry relied on to support or

endorse the clinical trials that are now ongoing, as your briefing note says specifically, "Furthermore, Ontario's position is strongly endorsed by leading PET scanning experts in the UK." So I'd like to know, if I could, Deputy, who it was and what evaluation they were relying on, because this letter seems to state that in fact UK experts are moving far beyond where Ontario is now, and that they are recommending that PETs go into cancer facilities, where we are at the stage where we're still trying to determine if this technology is going to be of benefit for cancer patients or not. So there seems to be quite a discrepancy.

Mr. Sapsford: Fairly said. I'll find out the information. I think it's important to note that there is a fair amount of controversy on this particular technology, as you're well aware, and Ontario's strategy has been to try to provide more evidence before decisions are taken. As I mentioned, one or two of the modalities, I believe, now are off the trial and more accepted as part of the diagnostics. But I'll clarify the points that you've raised.

Ms. Martel: Can I also then ask you if perhaps, when you get back to me, you would respond to this, because this was also a letter, of April 6, 2004, that went to the minister. It was from Dr. Driedger, who was part of the PET steering committee, who expressed some serious concerns even two years ago about the clinical trials and why Ontario was proceeding in the manner that it did. Perhaps I'll just read into the record some of his concerns.

"After three years of planning, no patient has been studied in any of the approved protocols. In the meantime, the technology has changed. We no longer need to evaluate PET so much as PET/CT. At the same time, there is increasing evidence to justify the use of PET in a number of oncological applications and the plan to obtain evidence of effectiveness in Ontario has in my view been used as a device for delay because of cost implications.

"I am a senior clinician who has had many management roles through the years. I am committed to the principles of evidence-based medicine, but I am frustrated that there is really more evidence available than some members of the steering committee are willing to admit. The result has been there is a delay that was not essential in the introduction of even limited clinical services. The introduction of PET as a clinical service need not represent the end of evidence-based evaluation."

His final comments are this: "When we first set out to evaluate PET in the Ontario framework, I was very enthusiastic about this approach. At the time, members of your ministry declared to me they would like to make PET evaluation the model by which to introduce other new technology into health care in Ontario. However, I have to say now that if the process is used again, it would be met with cynicism and scepticism. Effective review of new technology needs to be with that new technology at the cutting edge, and not lagging a decade behind, as is the case with PET today."

I think those were very significant concerns raised by a member of the PET steering committee itself about the choices Ontario is making with respect to the trials. I've been told the letter was not responded to. Perhaps when you get back to me about this, if you can clarify some of the concerns that were raised, I'd very much appreciate that.

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I also wanted to ask about—on page 5 of the briefing note there was a justification of why Ontario had moved in the way it did with respect to these clinical trials. The briefing note says the following: "The alternative to the clinical evaluation approach is the uncontrolled diffusion of PET at an estimated cost of $50 million, perhaps without benefit to patients." I would like to know how that figure of $50 million was arrived at, what factors went into making the determination that that would be the cost to the system if we didn't proceed in the way Ontario decided to with respect to the clinical trials. It doesn't say in the briefing note where that figure came from.

I'd also like to ask some questions about out-of-province. The briefing note suggested that there were 83 out-of-province PET scans that were approved between April 1, 2005, and February 13, 2006. These were for indications that are not covered by the ministry clinical trials at this point in time. I know that goes up to February 13, 2006, so it's pretty recent, but if you could let me know whether from that time till now there have been some out-of-country PET scans approved for indications not covered in the trials. I would like to know, if it's possible, what the costs are for the scans that are done out of province.

Further, on the same briefing note, I had some concerns about who gets to go out of province and who doesn't. The briefing note said that right now, if a physician determines that his or her patient requires a treatment that's generally acceptable by Ontario standards but is not performed in Ontario, they can apply to the medical consultant to go out of province, and that a process has been developed by Cancer Care Ontario to provide expert advice on whether the PET scans generally accepted in Ontario are appropriate for a person in the same medical circumstance. So I understand that Cancer Care Ontario is involved in that. I don't know what their guidelines are, but Terry's in the room, so we might find that out in subsequent questions.

What concerned me, though, was the next section, with respect to the randomized trials. Again, I don't pretend to have all the answers or understand clearly the difference between some of the trials, but this is the section I'm concerned with: "Patients whose OOC applications relate to indications consistent with the registry study or the two cohort studies are referred to these studies because all enrolled patients will undergo a PET scan. Applications relating to indications consistent with the three randomized control trials will continue to be assessed for an out-of-country PET scan because patients enrolled in these trials may not receive a PET scan."

So there are three randomized trials that are listed. My original assumption, before I got this information, was that everybody who was involved in the trials—the five

of them—were going to receive PET scans. Now it is clear that people in three randomized control trials will not, and I don't know how a determination is made as to who gets a PET scan and who doesn't in those three randomized trials.

Further to that, if people aren't getting a PET scan through those randomized trials, how would they know to ask their oncologist to refer them out of country for a PET scan somewhere else? I don't know how that process would then occur.

Mr. Sapsford: To some extent, that depends upon the structure of the trial and the details around it.

Ms. Martel: I don't have all the answers to that, so I'd be curious about how those decisions are made, and then, if you're not undergoing a scan and someone thinks you should go out of country, who's doing that follow-up, who's making the application for that to occur?

Finally, overall as a policy matter for the ministry, if it is good enough to send some patients out of the province for PET scans, why aren't we allowing them to have PET scans here in Ontario? That's a broad policy question—

Hon. Mr. Smitherman: I think to say that we're not is contradicted by the fact that in some cases we are. You asked lots of detailed questions which we'll seek to answer on that. The only observation I would want to offer is that very often a proposal will come forward to enhance the quality of care in a certain area. I think one of the obligations we have in the public health care system is to try and produce an equitable and timely result for those services which we've already undertaken. I would note that we came to office in a circumstance where—and we haven't exactly got this licked yet, but we've made some darned good progress on access to MRIs. I use that as an example. We've increased access to MRIs by over 40% since we came to office, with a view towards producing a more timely and equitable result.

I just think that sometimes in health care in Ontario people have leapfrogged to a new technology that maybe was not deployed in an equitable way. One of the challenges we've sought to address is to make sure that in those services we say, "These are going to be insured services," that we don't just offer them here and there but not everywhere and that we don't do it in a fashion which exacerbates some of the inequities that are already built into our public health care system.

While these trials have been going on, and the research and the advice that will follow on PET, we've been dedicating ourselves to trying to equalize and to produce a timely result around the other diagnostics which are already quite broadly disseminated—CT and MRI—but which still had very significant differentials on a regional basis. Sometimes you can make it seem like the consideration is a one-off, but on the broader issue of diagnostics, we've also been dedicating ourselves to that more equitable result on those things which we'd already taken on as insured services.

The Chair: Thank you. We have an understanding we're going to continue the rotation in order to complete today. Minister, if you're comfortable, I'd like to call forward Terry Sullivan at this point. I had a series of questions, and I'm not sure if Ms. Martel might have a couple as well. But if we're comfortable doing that, I'd call Terry Sullivan. Welcome, Mr. Sullivan. Just state your title, please.

Dr. Terry Sullivan: I'm Terry Sullivan. I'm the president and chief executive officer of Cancer Care Ontario.

The Chair: Thank you for being here today. I'm not sure if you read some of the Hansard from the last day where a couple of questions were raised. I wonder if I could just start with the response, and let me put on the record and thank the deputy and his staff for their efforts in getting answers back to us. They're very much appreciated.

I asked a question at the last sitting about oncologists' failure to disclose to patients the full range of treatments that might be available to them, whether or not they're an insured service. The response I got from the government was that the College of Physicians and Surgeons of Ontario has advised that the best interests of patients is central to all patient-physician interactions and that a physician would be expected, based on his or her knowledge, skill and judgment, to advise a patient on the most appropriate treatment options, given the patient's condition, regardless of whether or not an option is an insured service.

I've heard that, but that doesn't square with what we are hearing from cancer patients across the province. Since you have carriage of this enormous challenge, I wonder what your response is as to why so many oncologists do not raise the issue of access to other medications, whether or not they've been approved by the federal government, or have been approved by the federal government but aren't funded.

Dr. Sullivan: First, I would start by saying that I think the way the government has framed the obligation of physicians is entirely accurate; that is, it is a physician's duty to the best of his or her knowledge to disclose to patients the range of treatment options. Having said that, physicians take into account a whole range of factors, including the impact and consequence of this information on the patient's decisions, his or her personal circumstance.

1630

Most medical and radiation oncologists in Ontario are very familiar with the evidence for new and effective agents and new and effective treatments within weeks of the evidence being presented at major scientific meetings. This is one of the factors we're all facing, the increased pressure in the cancer systems in advanced jurisdictions. That is not true, however, of all physicians in Ontario. It certainly isn't true of general family practice physicians who may not be aware—

The Chair: We're talking oncologists here.

Dr. Sullivan: The fact that a drug may be funded or approved for use in Canada or not funded in Canada has to be a matter of judgment in terms of the disclosure the physician makes to the patient. I give you the example of

Erbitux, which has been in the press recently. This drug is not marketed in Canada, it's not routinely available here, so a physician is making a disclosure to a patient that this drug is available. That is really an invitation to travel out of province for an agent, and may perhaps—or not—be eligible for out-of-country coverage for that agent. That's an agent where the evidence of effectiveness has not been fully evaluated, but the evidence of its benefit is not entirely clear from the perspective of survival benefits.

The Chair: I appreciate the nature of the response. The concern is that not all oncologists in the province are telling cancer patients of the existence of drugs that are available in Ontario but not insured. Avastin is one, Erbitux is another, for colorectal cancer patients. In the case of Suzanne Aucoin, who we're all familiar with, from St. Catherines, she's getting her Avastin in Ontario and she's getting her Erbitux in Buffalo. One she pays for at the Juravinski clinic in Hamilton; the other one is paid for by the government of Ontario at Roswell.

Which brings me to the larger question: Setting aside for the moment that Avastin and Erbitux are funded by all G8 countries but unfortunately not ours, we spend about $6 million—the figure I was given—for cancer patients who receive treatment in the United States. One report I looked at indicated that we could serve as many as three times that many cancer patients, because it would be less cost to provide it in Ontario. As the person responsible for Cancer Care Ontario, have you looked at that equation? Have you looked at that issue, that for the same dollars we could access more cancer patients? You and I both have many examples. I just want to deal with this at a macro level if I could.

Dr. Sullivan: It's obvious to everybody in this room that the price of health services and most drugs is higher in the United States than it is in Canada. The process to try to determine which drugs are publicly funded in Ontario is a robust process. It's a process that brings the best of the available evidence, with all of our practice leaders here, to make a recommendation on the benefit, and that process is then adjudicated through the DQTC. I think the flaws in that process, to the extent that they've been called to public attention in the last little while, are that we need patient and public voice in this process, so those judgments reflect better the social consensus that's out there.

There certainly is a chain of drugs in the pipelines—not just cancer, but cancer is probably leading the brigade—which is going to be a challenge for all public formularies to agree to, based on their benefit and cost-effectiveness.

I'm not making a judgment about any of the recommendations and determinations by the DQTC. We are not party to this process in a visible way, and the records are not in the public record. We presented to the committee on Bill 102 recently, strongly endorsing the need for transparency and supporting the government's objective of transparency on this process.

Yes, we pay more for drugs out of country. The $6 million would not go very far in dealing with the funding of some of these new agents at a population-wide level.

The Chair: I'm merely referencing the fact that the specific treatment in the US—

Dr. Sullivan: Is more expensive.

The Chair: In Suzanne Aucoin's case, I got involved in it directly and was able to convince the federal government to allow for a special access permit after it's approval, and that saved her. That immediately cut her costs in half. I was fortunate enough to speak to one of your colleagues at the Juravinski clinic, because the next hurdle was to convince them, "Would you be a hospital in Ontario that would administer the drug and charge the Ontario resident the fee?" In Suzanne Aucoin's case, her costs ultimately ended up being one third, and that's just on colorectal cancer and just for Erbitux treatments.

I'm not arguing that we should be considering all drugs. I'm simply saying, for that small range of colorectal cancer patients in our province who are now being provided the service in Buffalo—and I appreciate that the government has approved those—that in fact we could serve three times as many or, perhaps to take a suggestion I wouldn't want you to take, you could cut your costs by a third. I see the opportunity to serve three times as many cancer patients who are seeking that treatment. That's the concern specifically, and if you are doing any kind of analysis and advising of the minister or coming forward with those kinds of recommendations—I guess colorectal cancer patients are applying to the government when in fact much of the decision-making rests within Cancer Care Ontario, and they'd like to have some sort of indication that there's some thought along these lines.

Dr. Sullivan: We are having a number of discussions with the ministry about the issue of out-of-country patients, as Ms. Martel mentioned earlier. We're trying to play a role in advising on out-of-country assessment for PET and perhaps for other cancer services going down the road. That's not been formalized yet to this stage, so as of this stage, we are not intimately involved in the out-of-country program. From the perspective of the drugs being available in Ontario, we are in the beginning stages of a dialogue with hospitals in Ontario about the availability of such agents in Ontario and the circumstances under which they would be provided.

The Chair: It's not just out-of-country; it's out-of-province. In the case of Avastin, I spoke with someone in the military who moved across the river because they could receive the treatment in Quebec. So it was worth his while to change residence, cross the river into Quebec and receive treatment.

I had asked a question last time about this whole equation about the value of a year of life per treatment cost to taxpayers, and cancer treatment routinely falls under this formulaic scheme. Although I haven't received paper back from the deputy and the minister, I'd ask you the question about why it is that in Quebec, we have a higher value of life per one year of treatment cost than we do in Ontario, considering the efficacy of Avastin is

not in question here. It's this question of whether the value of life per one year of treatment is worth it.

Dr. Sullivan: Just as a matter of clarity, I believe the situation in Quebec is the following: The Conseil du médicament reviewed Avastin in Quebec. Initially, they were not supportive of its use. They then agreed to allow its use, but it is not the obligation of all hospitals in Quebec to provide Avastin. It's a different story in Ontario. If we agree to fund an agent like this, it's available to all eligible patients. That is not the circumstance in Quebec. So just to be clear about the way it works in Quebec, it's a hospital-by-hospital determination about whether they fund this agent.

The Chair: But we don't have any in Ontario that are funding that agent?

Dr. Sullivan: That's correct.

The Chair: Finally, the question around Rituximab: There was some controversy between the minister and me over this drug and, to his credit, he conceded to additional funding under a new cancer drug program. Could you briefly update us that the age restriction has been removed, that the full amount was indeed invested in this treatment, and that it is ongoing for access for Ontario patients with non-Hodgkin's lymphoma?

Dr. Sullivan: That is my understanding. The age restriction has been lifted and a new indication has been approved for this agent. I don't have the numbers at my fingertips as to what those are.

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The Chair: Thank you.

Ms. Martel, did you have some specific questions for Mr. Sullivan?

Ms. Martel: I do. Do you want to go on to another set of questions?

The Chair: While he's here, and if Ms. Witmer has any. I don't want to monopolize his time. He's answered the questions I had.

Ms. Martel: Okay. Thank you. I did have a couple of questions.

When you came before the committee dealing with Bill 102, you had talked about patient participation on the joint DQTC-CCO committee that reviews new cancer drugs. I had moved a motion like that during the clause-by-clause that was not successful in being accepted. So my question would be—and it's either for you or for the minister—does this require legislation, to have patient representatives on the joint CCO-DQTC, and if it does not require legislation, would you be prepared then to put patient representatives on so they could be involved in that initial review of cancer drugs?

Dr. Sullivan: We would be happy to suggest patient or public representation for that purpose.

Ms. Martel: Do you know if it requires legislation, or is it essentially just a policy matter?

Mr. Sapsford: It's a question of policy. It doesn't require specific legislation.

Hon. Mr. Smitherman: Just for the trifecta answer here, obviously we're pleased to embed a citizens' council and the principles associated with citizen involvement in those elements of the bill that were dealt with in legislation. Over the course of the summer, we have a lot of policy work to do to back up the legislative regulatory framework. This is an issue which remains alive to us, that we will take a look at as we fashion the committees and the way that they will sort of interplay in order to achieve a greater degree of citizen participation. We'll look at the opportunities to enhance involvement, including on the committee that you've asked Terry about today.

Ms. Martel: I would appreciate that, because the reality is that the decision, at least with respect to intravenous cancer drugs, is essentially made by that committee. It is formalized by DQTC, and there will be patient representatives on the new committee to evaluate drugs to replace the DQTC. That's fine for oral medication, but the decision is essentially made around intravenous cancer drugs at that joint meeting, so you'd need citizen intervention or citizen participation on both. So that would be great if you could do that.

I wanted to just ask if you had any comments on some of the questions that I was raising with respect to PET scans, because I know Cancer Care Ontario has been involved—oncologists—on some of these trials. So if there's some other information that you can provide—

Dr. Sullivan: The one comment I might make is with respect to the review of out-of-country. We've had one of our senior radiation oncologists playing a role in reviewing a number of these cases now, and he is working with the existing practice guidelines and the existing trials process. He's also factoring in his own judgment to the extent that there are patients presenting with unusual circumstances where this particular imaging technology may actually alter the course of their treatment. There's no way that an individual trial or a guideline can anticipate all possible circumstances. So he's working with standards of evidence, but there are a number of patients who will be in exceptional situations who would be authorized, for whom he would be recommending out-of-country use for that purpose.

Ms. Martel: But if they are involved in the randomized trials and not getting a PET scan as a consequence, who is looking out for them in terms of making an application for them to go out of country, then?

Dr. Sullivan: Again, it comes back to Mr. Jackson's question about the disclosure to patients of what a physician thinks is best for the patient. The presence of a randomized trial, notwithstanding the fact that there's controversy, is usually an indication that the evidence is not yet substantive and clear and unequivocal of the benefits for a particular indication. While we have a number of indications that have been approved, there are a number that are entirely unclear. So the patient's physician may or may not feel that this is a beneficial procedure, for them to have a PET scan in order to be appropriately cared for. It's only those physicians who believe it would be.

Ms. Martel: Do the patients in the randomized trial know among them who will get a PET scan and who won't when they start the trial?

Dr. Sullivan: I can't speak to the details for the trial, but generally speaking, there are provisions to prevent that form of contamination. I'm not entirely clear how that is designed in these trials.

Mr. Sapsford: That's part of the follow-up.

Ms. Martel: I'd appreciate that, because I continue to remain concerned that you would have a group of folks who are part of the trial who would not get a PET scan, but could potentially get one out of province.

Mr. Sapsford: But in principle, that's what a randomized trial is. It's to gather evidence based on getting it versus not getting it. I think Terry started into that, but I'll clarify the specifics around how this particular trial is structured.

Ms. Martel: The final question I had with respect to PET is that we had a constituent who was involved in the trial in Hamilton but was not eligible for a northern health travel grant. Technically, I understood that, because you have to be receiving an insured service or go to a facility that is insured or cleared under the northern health travel grant, except that the trials are only occurring in southern Ontario. We tried to appeal it, but we were unsuccessful. I'm wondering if the ministry can take another look at those patients who are being referred from northern Ontario to the trials, for them actually to be able to qualify for a northern health travel grant, even though I recognize that we're not talking about a service that's been approved as an insured service at this point.

Hon. Mr. Smitherman: I can't promise that we'll resolve it, but I can tell you that I think at estimates prior I spoke about some work that we're doing currently to take a look at the northern health travel grant, and so we'll add this to those kinds of options/opportunities to see whether there's a condition that might accommodate it.

Ms. Martel: That would be great. Thank you. I don't have any other questions for you.

The Chair: Mr. Sullivan, thank you very much for being here.

Hon. Mr. Smitherman: I was hoping there were more questions for him.

The Chair: Oh, there are. I know the minister would like to thank you two for being here as well.

Dr. Sullivan: Thank you.

The Chair: Minister, I have two or three minutes left in this one rotation, and I just wanted to ask you a brief question about the assistive devices program. Burlington Breast Cancer Support Services recently contacted me to indicate that you have made a change to the rules of eligibility that takes effect on July 1, 2006. It means that for breast cancer survivors who need to acquire prosthetics, they will have to pay for the prosthetic upfront and that this will be a considerable financial hardship, particularly for older widowed breast cancer survivors. That is the concern being raised by breast cancer support services in Burlington. This will also be a major burden for those who suffer a double mastectomy, and they lead me to believe that there's no increase in the maximum amount for a double prosthetic.

Minister, could you help the committee understand just what we're achieving with your recent change in the regulations, and are you aware of the concerns being expressed?

Hon. Mr. Smitherman: I'm neither aware of the concerns being expressed nor of the exact nature of the rationale for the change. So the deputy and I will undertake to try and sort through that for you and to get back to you in a timely way.

The Chair: Thank you very much, Minister.

Ms. Martel, I'll return to you for your regular rotation.

Ms. Martel: I wanted to follow up from some comments that were made the last time we sat to Ms. Mitchell with respect to rural hospitals, and a couple of questions that relate directly to a hospital in Petrolia. I know, Minister, when you were responding to Ms. Mitchell, you said that a lot of the angst out there with respect to small rural hospitals has to do with them being in a vicinity of or networking with larger ones, and so the threat seems imminent that they might lose service or in fact are losing services. I want to ask a couple of questions with respect to Petrolia, because some folks who have formed what is called Charlotte's Task Force for Rural Health have been for about the last year lobbying with respect to their particular hospital.

The first question would be about a framework established under the Conservatives with respect to rural hospitals and designation of rural hospitals that went into effect in 1998. I wondered if the ministry is still working with that same document. Is that the same policy, that rural hospitals are designated A, B, C and D, or have there been any changes to that?

Hon. Mr. Smitherman: Well, to the best of my knowledge, there have not been any changes to that, but if we look at some other policy alterations that were made, including around the underserviced area program, we did lose some of our context in what I might describe as "rurality" or remoteness. There are a variety of different ways that, as you start to try and define—one of the things we've been grappling with at the moment is "small": What does "small" hospital mean? What I can tell you is that this is an area of active policy development from the point of the ministry. I've been pressing the ministry in the work they do with the Ontario Hospital Association through the JPPC to help to define for those smallest of hospitals a core set of services below which communities would never see services fall. This is designed specifically to address the circumstances that are ongoing in quite a few communities I've experienced as I've moved around, that any alteration to the services provided in a hospital seems to create the slippery-slope context that makes people feel like that decision point, small as it might be, is the end of a hospital that they hold near and dear. We're committed to keeping every hospital in the province of Ontario open, and we're committed to working with the OHA through the JPPC in

helping to define that work. I would say that the work at this stage is not particularly well evolved, but it's still part of an active engagement.

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I'd be happy to organize, as an example, a briefing for you on the work that's been done so far, but I would say, to my way of thinking—because I was a bit the instigator around this. I saw in a lot of places—it's evident in places even as large as Trenton, which is not a small community—fears about the preservation of local hospitals, and we've seen it in a variety of other places too. So this is an area of active policy work.

What I think we really need to get at here is restoring some sense of rurality. A measurement about Chapleau hospital must take into consideration how damn far it is from Chapleau to just about any other community with health services, not just Chapleau in a context measured up against the size of another hospital, but taking into consideration just how remote and isolated it is.

I'm not sure I've answered your question on point exactly, but to say that this is an area where the ministry is working pretty hard right now.

Ms. Martel: Perhaps during the course of that work you can look at some other things. This is a situation where the Health Services Restructuring Commission at first made a very serious recommendation to move from a hospital that was open 24/7 down to 18 hours, with a significant loss of service. The community rallied and there was a change in their designation, and they became designated as a rural hospital in C category, which should have a specific set of services attached to that. What happened in 2003 was that there was an amalgamation of this hospital with Sarnia General Hospital to form Bluewater. There were lots of concerns expressed to me about how that went on and who was involved in the whole process.

Folks would be interested in knowing—and I don't know what your position on this is either—how they would or may get their designation back as a C hospital. They have given me a list of quite a number of services that have been lost as a result of the amalgamation: 10 days a month of surgery; no dedicated anaesthetists; no gynecology surgery; the hospital no longer does emergency surgeries; no dedicated wound care nurse, as that's gone; they're down to 33 beds, no respite beds among them; a reduction of the staff in imaging; lost lab hours—a whole series of services that have been lost as a result of the amalgamation. They say that it's a result of the deficit of Bluewater; I don't want to go there. Their own hospital never had a deficit, from 1911 to the amalgamation, except for a small one in 2001.

As a result of the amalgamation, they believe, and I think they're correct, that they lost that designation because they were amalgamated with a bigger entity. What, if anything, can be done? Is the ministry prepared to look at reversing that particular amalgamation? I know you've done some things with respect to Women's College; that was a specific health services restructuring order. Are you open to looking at some others where people feel those services are going to be lost?

Hon. Mr. Smitherman: We have altered orders. I'm going to go by memory here, but I believe we've altered orders in St. Catharines, Kingston and Brockville, additionally.

I think that the real answer to your question is to be found in my earlier answer. I can certainly take under advisement the idea of restoring a designation, but to me, this is a hospital that's continuing to define itself by what it used to do, not by what it can do in the future. I'm not sure on face, just because there used to be respite beds in Petrolia, that we need respite beds in Petrolia now, because we're prepared to build and fund a residential hospice in Sarnia. So I'm not sure that on a case-by-case basis I want to have a discussion about Petrolia that is about getting back everything they once had. I'm not sure that's the vision for the future of their hospital. It is through the work of the JPPC, though, that we seek to be able to complete in a fashion which allows us to offer to the people of Petrolia more of an ironclad guarantee; that is, that the core services of their hospital would be defined by this basket below which it would not be reasonable for those services to drop. That is maybe what we could call critical mass. That's really the work that's ongoing at this moment.

On the Petrolia question, I'm going to spend a lot of time in southwestern Ontario in the summer. This is one of the areas where I already anticipate spending some time. I'll seek to get a little closer to the action and to gauge a little bit more carefully what options we have to give them a greater sense of confidence about the future of their hospital.

I went in to Wallaceburg, I went in last week to Napanee and I'm going to Picton soon. In each of those communities, it's been challenging in the sense that what we had to say to those communities is, "Your hospital has a proud history and it has a bright future." But in a time when health care services are evolving, where we've learned a lot about the necessity of providing a critical mass of clinical services in terms of being able to ensure a healthy outcome, we've got to really try and encourage those communities to look more to a future-focused vision. But we need to provide them with the assurance, with the confidence at the get-go that their hospital will be there on the longer term as a precondition towards being able to engage that debate.

In Wallaceburg, very soon after we were elected, there was a rally with 800 or 900 people outside the hospital, and I went and I sat across the table from 30 people who were very concerned. Save our Sydenham, SOS, was their moniker. They were concerned because they were losing obstetric services to Chatham, which I think is 22 kilometres down the road. But they really had a very low volume of obstetrics. Subsequent to that, however, that hospital has become an ambulatory care setting, and they're seeing their volumes and services increase, and they're feeling very relevant again. So this is the kind of challenge we have to face down. The JPPC work is

designed specifically to get at circumstances exactly like Petrolia. As we move forward in the period of the next six months or so, I'd say we'll be in a better position to characterize the Petrolia hospital in a fashion that helps to underscore what services must always be provided there.

Ms. Martel: The basket of services is important, but what they would argue is also critically important is who controls what goes on in the hospital. As a result of the amalgamation, there's a 12-member board, four representatives from Petrolia, and they are chosen by the bigger board, whereas when they had their own hospital corporation, there were elected board members in each case. So their argument would be, "Yes, we need a basket of services, but yes, we are also looking for a return to our own elected board to make decisions, funding flowing through us to the ministry, because we're not sure if we're missing out on some of this money because Bluewater has a deficit"—which everybody has been trying to deal with—"and our own corporation status so that we are clear that we are accountable for what is happening and not left to the mercy of someone else." But essentially, that certainly is part of their feeling in terms of what's been happening.

Hon. Mr. Smitherman: I think I can offer a more satisfactory answer on some elements of the question or statement than on others. I'm not of the opinion that we have the energy all across the breadth of health care to disentangle amalgamations, many of which have been in place for six or eight years. It's been clear to us in the case of Women's College and Sunnybrook that the benefits associated with going in a different approach were strong and that we should undertake it.

Two things I will say: Firstly, I think that we can—but on one of the core issues there, which is about making sure that all ministry dollars intended for that site flow to that site, the ministry has begun, but we have more work to do. To make that clearer, I'll give you a small example. One of the things we instituted after we came to office was, we take $60 million of our capital budget on an annual basis and make it available to every hospital in the province of Ontario. It's called health renewal infrastructure funding. This is really for the upkeep and care of buildings, because we found—lots of advice came to us that said, "Hey. Folks aren't maintaining their existing properties." Each of the sites in a hospital corporation warrants a contribution from HIRF, the health infrastructure renewal fund. But in the earliest years when we allocated that, we did not necessarily—it's not the best way to say it—disentangle the funding or demonstrate the actual site-by-site allocation. We've enhanced that. In one or two other areas of funding related to hospitals, we've teased out more of the information so as to make it more site-specific. I think we can do more on that. But I really think, again, that that flows a lot out of the work that we're currently involved in.

1700

On the board governance issue, I would not want to offer the promise to the people of Petrolia that our government was going to pull their hospital out of the current configuration and give them independent board governance. But I do think there are opportunities, and this is one of the areas where I've given advice to the Ontario Hospital Association, as it evolves in a post-LHINs environment, that there's a lot of room for them to operate in terms of our governance standards. What's clear to me is that we believe in community-based governance. We've adopted that as an adage. There's lots of fear about regional health authorities that have evolved in other places taking away those community board governors. We believe in them fundamentally, but if you look at it across the 152 hospital corporations, there's a very unequal circumstance there. In Northumberland, in Cobourg, for Northumberland Hills Hospital, people on the municipal ballot are elected to serve as hospital board governors. In other places it's much more closely held. There's a lot of room, I think, for us to enhance transparency around the operation of boards. We tried to set the leadership around that with respect to some decisions on the LHINs, including that they're going to have to make, in some cases, I suppose, challenging decisions in the full light of day with the public present. We don't think we've necessarily maximized all opportunities for hospitals to be similarly transparent. I would say this is an area where we can do better in the province of Ontario, to have a better standard of board governance. But it would be an area of future focus. I wouldn't say that we have the solutions at our fingertips at present.

Ms. Martel: A couple of other questions: The group from Petrolia has asked for a copy of the amalgamation agreement that went into effect in 2003. It was an amalgamation agreement between their hospital and the Sarnia General Hospital, that effectively became Bluewater, and they haven't been able to get a copy of that. Is that a document that the ministry can make available?

Hon. Mr. Smitherman: I believe it's a document that the hospital has the power to release or not release. That's top of mind. I don't know all the rationale for that, but as I've been down this path before, I think that is more the domain of the local hospital corporation.

Ms. Martel: If the corporation does not want to release that, what are the avenues for appeal for a community group to try and get that information?

Hon. Mr. Smitherman: To the best of my knowledge, none. In some cases, of course, the opportunity would be available there depending on the bylaws of the hospital corporation. In some instances, the opportunity would be there to influence the makeup of the board in such a fashion. I don't believe that exists in the Bluewater case.

Ms. Martel: They don't have the opportunity because the board is appointing other members. There's not an election, so it can't work that way either, where you can change some of the membership. If I can leave that with the deputy in terms of, is there any other mechanism—I think people deserve to know the conditions and the foundation upon which their hospital was amalgamated with another. If the hospital refuses to provide that, I think that's an issue we need to look at further, if I might.

Mr. Sapsford: I will look, but it is their agreement.

Ms. Martel: The one other issue is that because, Minister, you said you were going to be in southwestern Ontario this summer, the folks had asked, through Ms. Di Cocco's office, to see if they could get a meeting with you about this particular issue. That request was made September 2, 2005. They also made a similar request through Ms. Van Bommel's office. So I would ask if it would be possible, if you're going to be in the area, for you to have a meeting with some of the representatives of Charlotte's Task Force so that they can express to you directly their concerns with respect to their hospital and their concerns about making sure it's adequately serviced, and then you could talk to them about some of the issues you've raised with us.

Hon. Mr. Smitherman: I'm certainly going to be in both of those ridings over the course of the summer. I'll work with my local colleagues there to determine if that's a priority they want me to fulfill. I take lots of meetings. I don't take every meeting I'm asked to take. I'll defer to my local colleagues, but if that's a meeting they want me to take, that's not a problem at all.

Ms. Martel: They wrote back to the task force on September 26, "We have requested a meeting with Minister Smitherman on your behalf," but that's where it seems to have ended.

Hon. Mr. Smitherman: It's not surprising in terms of the volume of requests. Since I'm going to be in the area, that would seem quite practical.

Ms. Martel: They had some other questions because, as you know, there are some issues around what's going on in Bluewater and peer review. I believe they wrote a letter to your office on April 24, 2006. They were asking if the Ministry of Health was able to order an audit of books of hospital corporations, and in their response to me, said that according to a letter received from the minister's office, the minister cannot order an audit of Bluewater Health as it is an independent corporation. Does this make sense to you?

Hon. Mr. Smitherman: I'd like to see the letter and read the language myself rather than depend on somebody else's characterization of it. I believe we were all participants in a piece of legislation that allows the Provincial Auditor much more latitude around those things, including the capacity to undertake value-for-money audits, so there is that capacity. I would defer to the deputy to say, under laws related more specifically to the Ministry of Health, what actions we're in a position to undertake.

Mr. Sapsford: Hospitals are required to have, to start with, their own audit. Certainly the ministry has the powers, under its investigation and inspection powers, to audit hospitals. I'm not exactly clear—

Ms. Martel: I don't have a copy of the letter, so why don't I undertake to get a copy of the letter and then I can forward it to you so we can all know.

Mr. Sapsford: Could the ministry order a hospital, "You will do an audit on this day with that firm"? That's probably debatable, but there are other ways to address those questions.

Ms. Martel: I will undertake to actually get that so we can all know what they were—

The Acting Speaker (Mr. Bob Delaney): Ms. Martel, just to remind you, you've got about three minutes to go.

Ms. Martel: Let me look at rural health care a bit more. In terms of the work that's going on with the JPPC about a basket of services, are distance and isolation part of the criteria that are going into factoring how one gets a designation? Can you speak any further to that?

Hon. Mr. Smitherman: I already spoke to it, really. Only to acknowledge it as a core principle. I look at the underserviced area program as an example where the criterion—I think in her day as minister, Mrs. Witmer might have played a role in this. The problem with the alterations to the underserviced area program was that communities where there wasn't a full service hospital, where the challenge in terms of accessing services for a patient was much more dramatic, were lost. Oshawa: not to argue that Oshawa doesn't need physicians; of course, it does. I'm not making an argument to the contrary, because my sister lives there and I don't want to get in trouble. But to create a situation where Oshawa and Ear Falls, which has been without a physician for—I think it's been designated for 10 years. I think we've kind of missed a little piece of logic there. We've lost some sight of what I refer to as rurality, this measure of remoteness and the understanding that the implication is far greater in those communities, because there just are no other services. We don't prefer to say it's a good enough fallback on a hospital emergency room. Of course, none of us suggests that's the best place to go if you don't have access to primary care. At the same time, you can't argue that it isn't available when it is, when there is that backup, which in some communities doesn't exist.

As a matter of principle, on the work that we're doing, yes. But I will say that when you start to try to get to it, you say, "Well, 20 kilometres." Then some communities, town centre to centre it's 20.1 kilometres. You're going to argue that that's—so the arbitrary kind of distances and stuff like that alone doesn't get the job done either.

On principle, yes, but we have more work to do yet on what the best mechanisms are to unlock that. Like I said, it is a little bit still at the primary stages. They've done the first phase of some work. They're headed off into a subsequent phase. I rather think we're about six months premature in terms of having landed on some of those policy options. Probably some people back there freaked out that I said six months instead of nine. It's a tough bit of work, but we're really quite engaged and committed to it.

1710

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

Mrs. Witmer: Coming back to the issue of physicians: We know that new medical school spots have been created, but regrettably we're not hearing of new

residency positions. I'd like to know, what is your plan to create new residency positions?

Hon. Mr. Smitherman: The deputy will put some more information on the record, but obviously you have to work to do one in hand with the other. What we've sought to create is the capacity to address a shortcoming, a shortfall with respect to family physicians that relates to a period in Ontario's history where, for eight years, our medical schools were operating at a subpar level, not subpar in terms of their performance or the excellence of the doctors who were minted there, but subpar or less than optimum in terms of their quantity. We've been seeking to address that quite vigorously through a series of initiatives. The two that are spoken about most often are the medical school spots and the residency opportunities for IMGs. We've developed a series of other programs, as well, designed to help address this. I'm not sure if the deputy has some numbers at fingertip that might provide more information.

Mr. Sapsford: The current plan is, by 2009, a 15% increase in medical school enrolment. To the degree it's reflected in current and future years estimates, the policy position is, for each undergraduate training position in medical schools, the ministry will add the required postgraduate positions when those people are through their undergraduate. The expansion in the PG training complement is also part of the medical school enrolment.

Mrs. Witmer: That has really been an issue, as I said before, of concern to our own Ontario medical students, so you're not going to be creating them until such time as—

Mr. Sapsford: As they're needed. When the last year of the new trainees comes forward, then that would be the first year of adding the postgraduate positions to the complement.

Mrs. Witmer: Family health teams: We've seen a lot of announcements of the family health teams. How many are fully operational?

Hon. Mr. Smitherman: I think we have to be careful with language around these. Let me just put a little bit of information in the public domain. We've announced 150 of them in three different waves. On April 15, 2005, we announced 69. On December 9, 2005, we announced a further 31. This past April 6, we announced a further 50 teams. Forty-one of them to date are providing multidisciplinary care to Ontarians. I would say 41, but I wouldn't characterize those as fully operational. They will continue to grow. If you remember from our evaluation of the nursing numbers, we showed you those nurses who have already been hired in family health teams and those which have been funded for hiring in 2006-07, and then a further estimate of those who would be hired in 2007-08.

I wouldn't say that any one of them is fully operational, but I would say that 41 have come to life and are now providing multidisciplinary care where it wasn't provided before. That has resulted to date in 67,366 previously orphaned patients being able to say they are connected to a model of primary care. This is a piece of evidence that, as they ramp up, they're obviously going to capture quite a few more people yet. But 41 of the 150 announced are operating on a multidisciplinary basis. Each of them, even those 41, still has more growth yet to come.

Mrs. Witmer: How many of those were former family health networks?

Hon. Mr. Smitherman: We could certainly get you more of that information, and the deputy will do that. There's no doubt whatsoever that we have evolved other models of primary care, which were mostly about doctors working together without the multidisciplinary piece. There's no doubt whatsoever that some of the success we've enjoyed has been with people who were moving along the continuum, if you would, to more evolved models of primary care; others have been direct start-ups. One of the things that we've been impressed with more particularly even in the third round is the number of people who were making the direct leap from fee-for-service models—independent practice—over to the family health teams. So there's been a bit of a blend through those things, but we can certainly provide you with the statistics on each of them.

Mrs. Witmer: I'd appreciate that. I would ask you, how much money has been allocated to each one of the family health teams for the purposes of developing their governance and their business plans?

Hon. Mr. Smitherman: There have been different amounts allocated on a case-by-case basis, which is usually related to the size of them. As you may know, when we developed the family health team model, right from the beginning, my direction to the ministry was that we should be careful not to be too prescriptive, because we all know you don't have to travel very far to see the different circumstances.

So we've got family health teams that are evolving. For example, Seaton House, the men's shelter here in downtown Toronto: Last Friday I participated in the launch of one in your colleague Bob Runciman's riding, where they've got a motor home on the road that's going to deliver care to 16 different communities. Each of these, depending upon their scale, would receive a different allocation of resources from the ministry to provide it with what it needs to help to develop its business plans. But again, I'm quite certain that the deputy would be able to get more specific information about what resources have flowed to the various family health teams in terms of aiding them in their evolution.

Mrs. Witmer: I would like the amount of money that has been allocated to each one of the family health teams for the purposes of developing their governance and their business plans. That obviously is money that would go to consultants, lawyers or accountants, so it's per FHT.

Hon. Mr. Smitherman: I'll just say two things. I believe that it's not typically those professionals; it seems to be people who are consultants who have been active in the health care field. As an example, even organizations like the Association of Ontario Health Centres has looked to play a helpful role with respect to the emergence of some of these. I believe that the range of dollars we've

flowed for the preparation of those business plans—I'm going a little bit by memory here—is probably something between $30,000 and $80,000.

Mrs. Witmer: If I could have that breakdown for each one—

Hon. Mr. Smitherman: Sure. We'll work to get that for you.

Mrs. Witmer: Then, I guess, if we take a look at the family health teams, how many of them have fully completed the governance, business planning and the negotiation stage?

Hon. Mr. Smitherman: Similarly, I assume that the answer is at least 41, because those are the ones that have evolved. In those instances where we have an established relationship and funding model like a network, instead of hanging around waiting for every i to be dotted and t to be crossed, we've tried to initiate what we refer to as early wins, that is, to give some pre-approval for people to go out and start doing the hiring and acquisition of team members. We've tried, wherever we could, to get the wheels turning, even in advance of every ounce of paperwork having been completed. So we'll do our best to characterize those for you along the lines of the questions you asked.

Mrs. Witmer: If we take a look at the ones that have completed the governance, the business planning and negotiations, I wonder how many of those are now receiving their full family health team operating funding.

Hon. Mr. Smitherman: I would assume none, because none of them are yet fully mature, in terms of having all of the bodies that they—even where they've been approved for a number of bodies, many people are out there hiring at this moment. Since we met a week or two ago, our information is that there are 21 more full-time equivalents who have been hired; we'll update those numbers when it's appropriate. But obviously, they're evolving before our eyes.

In Brockville, I met two nurse practitioners who had not previously been employed by the VON who are now an essential element of that primary care team, but there are still more people to come. So I would say that none of them are yet receiving their full operational dollars, because none of them are yet fully staffed up. The dollars are there.

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Mrs. Witmer: If we take a look at the 150 announced FHTs, I'd like to know how many health care professionals are working in each one of those FHTs. I'd also like to know when these people were added to the team, and how many more individuals they plan to hire.

Hon. Mr. Smitherman: We'll be able to give you quite a lot of data that includes where hiring approvals have been provided. We may even be able to foreshadow, somewhat, towards what we think the mature state might look like. I'm not as sure what we can do for you on the last piece, but we can most certainly show you what the approval has been for the body counts in the family health teams and show you how many bodies of those are currently active.

Start dates? I'm not sure how much—but it will probably be more like, "As of date X, this is the snapshot in time."

Mrs. Witmer: The other issue has been the availability of information technology. How much money has flowed from the OMA and the ministry to the FHT doctors for information technology?

Hon. Mr. Smitherman: We will work to get that information. We will see what of that information is available.

You may know that one of the first acts of our government was to fulfill an element of the deal that your government had completed with Ontario's doctors. There was an outstanding issue there related to the flow of $150 million for technology. We fulfilled that commitment quite quickly. The OMA, I think, would acknowledge that it took them a little time to start to get those resources out the door. The money: Based on the anecdotal experience that I'm getting from front-line engagement with docs, that's improved quite remarkably, quite dramatically in the last six months or so.

Deputy, is it appropriate for us to work with the OMA and to try—and get you the numbers that you're looking at.

Mrs. Witmer: I understand, actually, that the distribution of that money has only recently started, that it's been extremely slow.

Getting back to the staff at the ministry: How much money have you at the ministry allocated for ministry staff to provide support to the FHTs in their early stages?

Hon. Mr. Smitherman: That's a very specific question that deserves a very specific answer, which we will get for you.

Mrs. Witmer: Okay. How much money has been spent by the ministry on FHT support since your very first announcement in February 2005? Also, how much will be spent this year on staff?

Hon. Mr. Smitherman: We'll do our very best to provide those things. I think in some cases people who are working on FHT files will have broader responsibilities for the broader array of primary care models. The deputy will do his best to disaggregate information along the lines of what you've requested.

Mrs. Witmer: Okay. I'm going to jump now, because I know my time is almost up, to newborn screening. My question would be: What is the status of a central database for incidence follow-up for newborn screening?

Hon. Mr. Smitherman: I can't speak specifically to that element of the newborn screening initiative. Perhaps someone will be able to provide the deputy with a note on it. I was, by coincidence, in Ottawa on Thursday and did a fundraising event with CHEO and one of the family groups to raise money in support of that program. Of course, the equipment that they're dealing with has all been delivered. It's in the midst of being calibrated, which is a very precise—and they're adding a number of screening tools with a view towards being ramped up to 28, I believe. That's the number that we intend to be in a

position to test for by the end of this calendar year; I believe that's the ramp-up.

It doesn't answer your specific question. We will seek to get you an answer to that.

Mrs. Witmer: By the way, I want to congratulate you on the expansion of the newborn screening. It's very much appreciated.

Will that new central database for newborn screening in Ontario include hearing incidence and follow-up?

Hon. Mr. Smitherman: I believe it will, because hearing is, of course, one of those things that Ontario has tested for over quite a good period of time. I must confess to being a little bit less familiar with the references to database, so I just want to have a little caveat there, which is to say, I've got a little bit more to learn on that point. But my instinct tells me that it would be part of that overall system.

Mr. Sapsford: Mr. Chair, if I might just clarify, you're referring to the database associated with the newborn screening program?

Mrs. Witmer: Yes, because the screening process for hearing impairment is different than the blood spotting testing done for most other tests in Ontario. So I'm just saying, is it going to include—

Mr. Sapsford: Sure. You're trying to understand if it's integrated.

Mrs. Witmer: Yes.

Mr. Sapsford: Okay. I'll clarify that point. The database for the blood-based screening program is part of the CHEO program. So, as the minister has said, it will begin to develop as the testing itself is scaled up as they add the tests over the course of the opening of the lab.

Mrs. Witmer: Will any of that data be made public?

Mr. Sapsford: This would be private health information, specifically. It would be made available on a—

Mrs. Witmer: On an annual basis?

Mr. Sapsford: Certainly for secondary information, I suspect, we'll be able to look at statistics to make sure that the appropriate numbers are being screened and what the results of it are for future planning.

Mrs. Witmer: Before my time is up, I just want to express my appreciation to the minister and, obviously, the minister's staff and Mr. Sapsford, the deputy, and certainly the Ministry of Health staff who are here and those who have worked behind the scenes. I know from personal experience that a lot of time and effort goes into preparing for this estimates, and I do appreciate, all of you, the time and effort you've put into this. I look forward to receiving some of the other answers, but anyway, thanks so much. It's a tough job, and you've done it well. Thanks, George.

Hon. Mr. Smitherman: You're very kind to say it. They're a hard-working bunch, that's for darn sure.

Mrs. Witmer: They sure are.

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

Ms. Martel: On that note, I should also express my appreciation, because at some point I might have to go upstairs and help Mr. Marchese call for a vote. I will go through as many questions as I can before I get the nod to go out of here.

I wanted to ask some questions about public health. Minister, you may not have seen this letter, because it was actually addressed to Dr. Basrur. It was a letter from the Association of Local Public Health Agencies, dated May 23, requesting a meeting with Dr. Basrur specifically to encourage the ministry to reconsider the current policy direction of reviewing board of health grant requests that provide for up to 5% growth in 2006, and essentially the cap that is in place. If I can just read some of this into the record, and then if you can respond—you and/or Dr. Basrur—that would be wonderful.

She says the following: "Board of health chairs and medical officers of health received the letters informing them of this policy direction on March 3 and 4, respectively. Given the January to December fiscal year for boards of health, most had already completed their budget cycle by the time this policy direction was received. We are asking that the 65% Ministry of Health and Long-Term Care grant for all board of health approved budgets be fully funded. A cap on public health funding growth at this time is not acceptable as it will jeopardize the ability of boards of health to fulfill their obligations under the Health Protection and Promotion Act and mandatory health programs and services guidelines."

Further, "For the past five years, health units have been on a path to achieve 100% compliance with the minimum standards outlined in the mandatory health programs and services guidelines. Boards of health remain committed to this goal and are working towards levels of health unit funding that will achieve 100% program compliance. Limiting board of health grants at this time will have a negative impact on the ability of health units to reach the 100% compliance they have been working to achieve."

ALPHA did a survey of its member groups asking them for information with respect to the ministry's policy in this regard. The following is the information they received back from 33 of the 36 health units:

"The survey results indicate that total health unit budgets (including mandatory programs, unorganized areas ... and infection control) have increased on average from 2005 to 2006 by 15.2%. The increase for mandatory program funding alone is 13% on average across the 33 health units that responded to the survey. Sixty per cent of the health units reported that this budget level would allow them to 'mostly,' 'almost completely' or 'completely' fulfill the requirements of the mandatory health programs and services guidelines.

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"In addition to the impact on the ability of boards of health to meet their legislated requirements, this policy direction places an increased financial burden ... on municipalities. Rather than paying 35% of the mandatory programs budget, funding direction communicated in March will result in municipalities paying an average of 40.8% across the province. This represents an additional $35.5 million from the municipal purse...."

It then goes on to say, "At this time, I would like to request a meeting with you"—that was to Dr. Basrur—"to discuss the board of health grants for 2006."

I certainly know there was a lot of controversy in my own community between the chief medical officer of health and the health unit and the municipality, which frankly assumed that with the province paying more of the share, they might be in a position to withdraw some of theirs. But the budget that was brought in, of course, in our own community just to try and meet mandated programs was much above that. I wonder, Minister, if you want to respond to these particular concerns that have—I think it went out to all members, not just to myself.

Hon. Mr. Smitherman: Sure. Well, a few things; I think the deputy might want to say a few things as well.

Firstly, the issue of a mandatory program is really a foundation upon which it's appropriate to build a public health system and to make decisions. The reality is that that's work that Dr. Basrur will lead public health units through next year. So the letter may offer some characterizations in three columns that sound a bit like public opinion polling answers, but this is in a certain sense work that's yet to come. I found the letter—the parts you read—a little bit interesting, especially when it tends to want to try and play both ways the issue of the upload, that is, the amount of increased resource that the government of Ontario is providing for the provision of public health. I would be very interested in seeing municipal leaders sit across the table and mischaracterize, as the letter does, the implication of the uploading cost.

In 2003-04, when our government came to office, the government of Ontario's commitment to public health totalled $234.8 million. In 2006, it's $385.7 million, a 64.2% increase. That's a combination of growth and of upload. There's no doubt whatsoever that the upload has created different capacities and opportunities for municipalities, and some have chosen to deal with it by taking the upload, if you will, back into their budget for reallocation to other priorities. The majority of municipalities, I think, have chosen to leave it in place.

The question that I would ask in response to those public health units, and I assume this is the nature of the question that Dr. Basrur might ask, is, who thinks 15%, year in and year out, is a sustainable circumstance? I think that in an environment where we've seen evidence that public health units over a period of time have chosen to interpret regulations on an increasingly aggressive basis, this is a sign that there isn't among public health units a consistency in the work that they do, that they are adding each and every year, it would seem, reach. I have no other way to explain a circumstance where a regulation that's been on the books in one case I think since 1984, and in a second case since 1990, has evolved to such a great extent that public health units are on the job and pouring bleach on egg salad sandwiches in Windsor.

I do have some concern about the allocation of public health resources in a fashion which is designed to address those risks that we're most aware of, and I think it's totally appropriate in an environment where we seek to be able to sustain our public health care system that we ask people to operate within a range much closer to what ought to be expected to be reasonably available. I do feel that through the resource allocation we've made in the public health area, our government should be and is very, very proud of the commitment we've made in this area, which is well reflected in the fact that from last year to this year the increase in funding for public health units has gone from $303 million to $385 million. So I think that provincial dollars are well disseminated in the public health world. Municipalities have a broader array of choices before them than they've had in quite some time, and we've got further increases to make in terms of that upload, which, combined with the 5% increase for growth, leads me to the conclusion that the public health area is being appropriately resourced, pending the determination and outcome of mandatory program review work, which Dr. Basrur will be leading.

Ms. Martel: Is it your view, then, that public health units are misinterpreting their obligations with respect to mandatory programs?

Hon. Mr. Smitherman: It's my view that anyone will use language like "mandatory programs" to try to stimulate the desire to get 15% increases in their budget. But at a certain point in time, someone's got to take a responsible position which says that whoever out there thinks that the era of an 18% increase one year and 15% next year is sustainable is operating in a slightly different context than most of the rest of the world. I do think that an environment where we've seen the capacity of public health units to expand their operation into areas that for a long period of time hadn't been their focus raises questions about whether the issue of mandatory programs is one that is evolutionary or whether it's consistent. That's why I keep going back to this issue of the mandatory program review work. That is really an essential piece that's missing here and that can inform us better on a going-forward basis about what the appropriate response is to the challenges of mandatory programming.

The bottom line is that the amount of resource that the government of Ontario is contributing to public health has dramatically increased over the circumstances that we inherited, and we have every confidence that public health officials, doing the hard work that everybody in health care and, frankly, everybody in the public sector is asked to do, have sufficient resources to be able to address their important responsibilities for the protection and promotion of the public's health.

Ms. Martel: If the concern is what is mandatory and the ministry is committed to a review, then it would be incumbent on the ministry to deal with that as soon as possible from this perspective. The calendar year is not the same as the fiscal year, so you'll have public health units going in within the next six months to determine a budget starting January 1, 2007. I don't know the whole schedule with respect to the review and when that's

expected to be complete, but you'd essentially run into another budget cycle, where you're going to have those discrepancies, then, among public health units about mandated programs and how they respond to them.

Hon. Mr. Smitherman: It's on a case-by-case basis. There are 36 public health units, just like there are 152 hospitals. They haven't all been constructed the same. They don't all have the same administrative structures; they don't all have the same guidance and leadership in terms of what direction the public health unit takes from boards. So it is a circumstance where we're forced to unravel it, disentangle it—I don't know what the best word is—on a case-by-case basis. We do that every year. In terms of the suggestions with respect to timing, that's why we felt it was incumbent upon us to signal quite early in our fiscal circumstances, acknowledging that the municipal year is slightly different, what a reasonable expectation is, and to note also that with respect to the upload—I'm going by memory here, but I'm pretty sure—we followed the municipal line with respect to that.

Again, to make the point, it would be very easy to take out of context the issue of 5% for growth. The reality is that across the landscape of municipalities and the important work they do in public health, there are many more dollars available than in the circumstances we inherited as a government. Like I said before, we have the utmost confidence that public health officials in the province of Ontario are being appropriately resourced to fulfill the important functions they have.

Getting into a discussion about mandatory programs is rather difficult in a context where it requires us to understand the underlying fundamentals in each and every one of the public health units. That's the work that Dr. Basrur and her staff have got capacity around, and that's why they work through these budgets on a case-by-case basis.

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Ms. Martel: What is the timing for the completion of the review? Has it started yet or is it—

Hon. Mr. Smitherman: No. This is work that's forthcoming. You may know that the capacity review committee came forward with some recommendations in the last number of months. Then they moved their energy to the mandatory program work, which is another piece of the puzzle that's necessary to make some decisions about how we might evolve the public health system in Ontario to address some of the underlying challenges that we've all known about, including the challenges in some of the less populous public health units to have the level of expertise that we would all desire.

So that is to say that the CRC—the capacity review committee—obviously gave some advice about mergers and amalgamations of public health units. I take the view that until such time as we have the mandatory program analysis review done as another one of the pieces of information, it would be inappropriate to make decisions. So that work will be forthcoming, and Dr. Basrur's team will be leading public health officials through that in the coming days.

Ms. Martel: Just to be clear, though, do you have the timeline for that work?

Hon. Mr. Smitherman: I just see it as something that we would expect to be complete by around this time in 2007, within a year or so of now. There probably are slightly more ambitious timelines out there, but this is a hard bit of work, and I'm seasoned enough by now to try not to put an actual date down there until I've seen how it evolves, with my experience with the delivery of long-term-care legislation firmly in mind.

Ms. Martel: Just so I'm clear—

Hon. Mr. Smitherman: I had to say it before she did.

Ms. Martel: She wasn't saying anything at the back.

My next question was going to be on the recommendations contained in the capacity review. So what I should understand is that the focus is going to be the review of the mandatory programs?

Hon. Mr. Smitherman: The whole ball of wax. To me—I'm sorry. I interrupted you.

Ms. Martel: That's the question. I mean, there are issues about recruitment and retention that came through in that. There are issues about governance structures, which are controversial, with respect to amalgamation of public health units. So there are a number of issues in there, some I would argue really critical, like recruitment and retention of medical officers of health, inspectors etc. I don't know if your response is going to be coming as a complete response where you're going to try and deal with recruitment and retention of somebody—

Hon. Mr. Smitherman: You can't piece-meal the issue of recruitment and retention and have that as a set-aside, because obviously one of the recommendations that that called for was the amalgamation of health units down to 25 or to 26. Well, you didn't do that. You can't do that and not do the governance bit. That's why I'm saying—and I said to people, including in Brockville where I was asked about the CRC report—that's one more piece of the puzzle, but don't expect that the government will be responding to that in totality until such time as we've had an opportunity to look at the mandatory program stuff.

It's not to say that there aren't elements of the CRC report that Dr. Basrur might want to bring forward on a case-by-case basis—of course, we'd be very open to that—but I do think that the mandatory program review work does set us up better for the nature of decisions that the government of Ontario must make to look to the future of public health over a multi-decade horizon.

Just to be very forthcoming, one of the options, no doubt, that some will be pushing the government—because by the time we're doing that, we're going to be up to 75%. We'll have done another tranche of uploading, and some people will be suggesting models that include the province of Ontario taking the complete responsibility for public health. I don't have a view on that yet, because I don't feel like I've got enough information to be able to formulate all of the best policy

options around that, but just to give you an idea of how much stuff there is out there on the landscape and how many exciting opportunities are going to be before us in terms of what model we develop. I just want to be very clear in saying that no decision is going to come out of the blue and surprise anybody around this. Our decision-making with respect to the future of public health will be a very deliberate decision-making process and one that gives lots of opportunity for engagement.

Last point: We work really closely with the table that has been constructed by Minister Gerretsen, the AMO-MOU table. That's proven to be a very effective place for us to try and have some conversations with municipal leaders so that we can be well apprised of the various options and ideas that are out there.

Ms. Martel: Just with respect to one other public health report that's out there—I don't have it with me; I apologize—even before the capacity review report came out, there was the other report on how to revise the landscape for public health, the research capacity, the new public health lab etc.

Unless I've missed it, and I may have, I don't think there has been a formal response, because the second report of the task force is now in. Do you have a sense of your timeline around that?

Hon. Mr. Smitherman: I don't know what we anticipate doing in a public context around that, but I could tell you—and the deputy probably will have a fantastic answer. He usually does. I think that what I would want to tell you are two things. Firstly, the public health labs and the issue of the public health agency are both ones where the estimates reflect progress. I can't tell you on exactly what page, but we are working to bring the public health agency to life. You see through the estimates an ascending level of funding associated with that.

Also, some resources to enhance the capacities from a capital equipment standpoint of the public health labs. The public health labs remain for us a pretty significant concern. We've worked really, really hard to try to rejuvenate them, but it's proven to be one of the more difficult pieces of work that we've undertaken.

That would just be my top-of-mind view of that. I'm not sure if the deputy has more information to impart.

Mr. Sapsford: Just to follow the minister, the ministry's now busy looking at the implementation questions that arise and developing the options around the governance questions and so forth. Those points will go back to the government for final decision-making. But the planning process is well under way.

Ms. Martel: I apologize because I don't know where that is in the estimates, but I'll go back and have another look at it in terms of seeing what the funding is that's allocated. But it would be both operational and capital?

Hon. Mr. Smitherman: In two different—I'm not sure—in two different spots. The public health labs are not distinctly part of the agency.

Mr. Sapsford: I don't have the exact figure. The operating part of it is in the public health estimates. The change year to year is $128.5 million. A portion of that $128 million—I can check the exact number—is directed toward agency implementation in the current fiscal year. It will not, in this estimate, represent the full cost of operation simply because of the time frame from implementation.

Ms. Martel: For it to roll out.

Mr. Sapsford: The planning dollars and the beginning part of that are included in that part of the estimate.

Ms. Martel: Okay, thanks. Do I have a bit more time?

The Chair: You have two minutes.

Ms. Martel: Okay. Very briefly. The deputy might respond to this only because he and I have had some ongoing correspondence. You'll recall that I raised some questions when we were dealing with ambulance services in the public accounts committee. I raised some specific concerns about unorganized communities and the method of payment by the Ministry of Health for services that are provided by district social service administration boards, and that the government—

Mr. Sapsford: Yes.

Ms. Martel: Okay. I did receive your letter back, and I sent it back to the DSSABs I deal with. I think that we require another go at this, Deputy, if you don't mind. I would like to be able to contact you again about this. Every other ministry can get the money to the DSSAB on time. Health is still the only one that's delayed. I cannot for the life of me understand that discrepancy.

Mr. Sapsford: Perhaps, Mr. Chair, I could commit to review the question.

Ms. Martel: That would be great.

The Chair: Thank you very much.

Hon. Mr. Smitherman: Because we work to try to be more timely around that.

Ms. Martel: It has quite a significant implication—

Hon. Mr. Smitherman: Sure.

Ms. Martel: —when the year is lapsed for what small municipalities are trying to pick up.

The Chair: Minister, thank you very much, and to your deputy, especially. The timely response for several of the questions is very much appreciated. It seems to have been a problem. Your level of commitment and co-operation is appreciated.

We are now deemed to complete our estimates for the Ministry of Health and Long-Term Care. I wish to proceed through the votes. Agreed? Agreed.

Shall vote 1401 carry? All in favour? Opposed, if any? That is carried.

Shall vote 1402 carry? All in favour? Opposed, if any? Then it is carried.

Shall vote 1403 carry? All those in favour? Opposed, if any? It is carried.

Shall vote 1405 carry? All those in favour? Opposed, if any? It is carried.

Shall vote 1406 carry? All those in favour? Opposed, if any? It is carried.

Shall vote 1408 carry? All those in favour? Opposed, if any? It is carried.

Shall vote 1409 carry? All those in favour? Opposed, if any? It is carried.

Shall vote 1407 carry? All those in favour? Opposed, if any? It is carried.

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

Shall I report the estimates of the Ministry of Health and Long-Term Care to the House? Those in favour? Opposed, if any? It is carried.

Thank you very much, Minister and Deputy, and to your staff for being here.

This committee stands adjourned. I believe the House leaders will give us permission to sit for four full days during the intersession. We will begin with the Ministry of Health Promotion for seven and a half hours.

This committee stands adjourned.

The committee adjourned at 1754.

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Mr. David McIver, research officer,
Research and Information Services