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Wednesday 11 June 2008

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Mercredi 11 juin 2008

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: Tim Hudak
Clerk: Sylwia Przezdziecki

Président : Tim Hudak
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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON ESTIMATES

COMITÉ PERMANENT DES BUDGETS DES DÉPENSES

Wednesday 11 June 2008

Mercredi 11 juin 2008

The committee met at 1601 in room 151.

MINISTRY OF HEALTH AND LONG-TERM CARE

The Chair (Mr. Tim Hudak): Good afternoon, folks. Welcome back to the Standing Committee on Estimates, the afternoon meeting of Wednesday, June 11. When last we met, the official opposition had just completed its 20-minute rotation, so we'll start with the third party.

A couple of housecleaning matters: Folks, as you know, we cancelled yesterday's afternoon meeting because we had the opposition day motion on C. difficile, so obviously the critics and the minister and the PA would want to be following the debate in the Legislature. The consequence of that, however, is that we will need one additional day of this committee, which is Wednesday, June 18, as it stands today—the afternoon session. We currently have an hour and 15 minutes or so, so we'd meet from 4 till 5:15, as it stands today. There is a possibility that we may not have to meet, but you'd have to have some sort of all-party agreement to drop time. I'll leave that in the hands of the critics and the parliamentary assistant if you want to negotiate something like that. Failing that, Minister and Deputy, we will require you back on Wednesday, June 18, for at least an additional hour and 15 minutes, depending on our timing today.

Mrs. Elizabeth Witmer: If the House isn't sitting on Wednesday?

The Chair (Mr. Tim Hudak): If the House recesses for the summer, we do not have permission to sit during the summer. We will come back according to the calendar in September, which means that health will carry over until the House resumes in the fall.

Mr. Gilles Bisson: Just on that, because there was a request by the subcommittee in order for us to meet during the intersession, that is more or less agreed on. It's just a matter of the subcommittee ordering up its business. The whips will work it out.

The Chair (Mr. Tim Hudak): We needed a motion in the Legislature, though, to enable us to meet earlier in September.

Mr. Gilles Bisson: Yes, and there was a discussion for that to happen. Hopefully, that'll get worked out, so what I'm saying is, hopefully that motion will be ready for next week. The subcommittee has already given some dates in September, and if everything is okay, we can probably do that. We'll try to work it out during the next week.

The Chair (Mr. Tim Hudak): Okay. Just to update committee members, I did write on behalf of the subcommittee to the various House leaders to ask if we could meet earlier in September than the regular schedule and continue to meet in September even if the House doesn't sit at its regular time. Hopefully, we'll have a positive response from the House leaders, because we do need a motion in the assembly.

I think that's it for caretaking business. We now begin—

Mr. Lou Rinaldi: Just to follow up on your original suggestion of trying to wind things down: When do you suggest we have the discussion? At the end of this meeting?

The Chair (Mr. Tim Hudak): I think I'd prefer to have the leads for each party discuss offline, if you have a chance. If you can't work something out, we have that extra day, and if the House adjourns before Wednesday, June 18, it carries over to the fall.

Mr. Lou Rinaldi: Okay, thank you.

Mr. Gilles Bisson: Thank you, Chair. I'll hand the word over to my colleague, Mme Gélinas.

There's an agreement between the three parties—ourselves, the Liberals and the Conservatives—to stand down Mme Gélinas's rotation, because she has to be in two committees at the same time. She will move her motion. I don't think you need a motion, but you can try anyway.

M^me^ France Gélinas: I seek unanimous consent to talk—it was my turn, and I was very much looking forward to having my turn, but I have to be at Bill 69, so I was wondering if you could skip me. I still want to keep my 20 minutes; it would just be added on the next time it comes to me.

The Chair (Mr. Tim Hudak): Sure. That's not uncommon. So in the next rotation, Madame Gélinas would have 40 minutes as opposed to 20.

Hon. George Smitherman: How am I supposed to withstand that?

The Chair (Mr. Tim Hudak): I do need consent from the members of the committee. Any objections? Super. Okay, that's fine. We'll stand down the NDP's time until the next rotation, when they will get 40 minutes.

Hon. George Smitherman: Mr. Chair, I have two pieces of information that we've left with the clerk,

which are partial answers to some of those questions that have been posed so far.

In an exchange with Mrs. Witmer, I committed to get back to the committee with information from the public accounts of the detailed expenditures related to the health premium. I had also promised to supply a press release—which actually is issued in your name, Mr. Chair—which continually calls for the elimination of what you refer to as the so-called health tax. Mrs. Witmer had put on the public record that that was no longer the position of your party, but I was aware of this release and I have now provided to the clerk copies for all members of the committee, which has you reiterating calls for reductions in the health premium.

The Chair (Mr. Tim Hudak): The so-called health tax. Have we distributed the information to committee members? We're in the process of doing that? Okay. Minister, thank you very much.

We have government members for 20 minutes. Mr. Rinaldi.

Mr. Lou Rinaldi: Good afternoon, Minister. This is the first time we get to ask a question. Oh, sorry; Mr. Craitor did last time.

Mr. Kim Craitor: I asked one of my 464.

Mr. Lou Rinaldi: Your 464—so I can see that this is going to be a long session.

Minister, as you know, we've made a large commitment to engage Dr. Hudson in some extensive ways to reduce ER wait times. I know that in our 2008 budget, we included some $180 million over the next three years to make continuous improvements in emergency department wait times to satisfy some of the patients' needs. You've also made an announcement about your plans for reducing ER wait times across the province. Can you give us a little bit more detail on what that entails?

Hon. George Smitherman: First, I want to say that emergency room wait times are challenging. Mrs. Witmer had the opportunity to grapple with them and so have we, with differing results. In some places, we can point to improvements, but overall, we'd have to conclude that they're not performing at a level that is satisfactory to us or, more particularly, to our patients, who own the public health care system.

We think that we can make good strides, and a good bit of our confidence is informed by the fact that Dr. Hudson and his team have made really great progress in reducing wait times for Ontarians. The Canadian Medical Association gave Ontario the highest rating of any jurisdiction in terms of that work.

Firstly, we've summoned the leadership capabilities of Dr. Hudson, and he's added already to his team with Dr. Schul from Sunnybrook and Kevin Smith, the CEO of St. Joe's in Hamilton, to make some progress on this.

Our budget initiatives over the next three years will include about $180 million in additional resource targeted specifically to emergency rooms. The announcement that we had the privilege of making just about 10 days or so ago was the first tranche of resource, $109 million, substantial amounts of which are dedicated to enhancing the services which can be provided in environments outside of the emergency room but would have the effect of influencing what's happening there.

Emergency rooms very often struggle because they can't pass the patients along to the rest of the hospital. The reason for that is that patients who would be most appropriately cared for in other settings are in those beds in the hospital. So substantial resource is being driven to enhance the capacity for home care to take more responsibility for some of these patients who are in hospital beds but who could be at home with a greater degree of service. So we've moved forward with regulatory changes which raise the ceiling on the amount of care that community care access centres are able to coordinate on behalf of patients.

We've also taken initiatives which are designed to assist with ambulance off-load delays. In the Niagara press today, there are stories about ambulance off-load delays. We're making an initiative that the EMS approached us about, which will see the government paying for dedicated nursing resources that will take the place of paramedics so that paramedics won't be in a position where they have to wait with a stretcher while the patient is being transferred into the hospital but rather keep those ambulances rolling and able to respond to 911 calls. They'll be out on the road.

1610

We also have an initiative which is designed to try and stabilize individuals in the environment where they already are: long-term-care homes, which house 78,000 of our most vulnerable patients. Many transfer from long-term-care homes into the hospital environment. You could imagine that for an 83-year-old, on average, this is a very disruptive process. We're going to spend $4.5 million to create teams of nurse practitioners or advanced practice nurses who will go and work in the long-term-care home environment to stabilize patients who would otherwise be under pressure to be transferred to the hospital environment.

In addition to that, $22 million has been transferred to local health integration networks, which will, in partnership with all of the various provider organizations in their LHIN, develop strategies that are designed to reduce the burden of alternate-level-of-care patients, who are, at present, a substantial part of the challenge of the performance of hospital emergency rooms. Noteworthy is that the approach to fix the emergency room is in large measure about dedicating resources elsewhere in health care to improve the flow and process in the hospital emergency room environment.

Last week we made those strides with $109 million. What we'll be adding to that is a toolbox of things that we expect hospitals to implement, focusing first on 23 hospitals in Ontario that have poorly-performing emergency rooms, tending to be our largest hospitals. Sometimes that's because they're dealing with a burden of patients which is quite high. We will be approaching it with what I would characterize a little bit as a carrot-and-stick approach: We will put some additional resources in

to try and augment some of the care that is available there, but we will also be making sure that those hospitals are taking strides along the lines of best practices which are well-known in the health care environment. We'll be adding to this with targets and actual measures of what's going on in the hospital emergency room.

I'm giving you a lot of information, but there's one thing that I really want to drive home: You can go to a hospital emergency room and receive timely care, but it doesn't necessarily guarantee that the patient's experience, the patient's satisfaction with the experience, is fantastic. We have to work on the amount of time that people spend, but we also feel that there's improvement that can be made in the nature of the environment that people are experiencing. We have some work to do to try and defuse some of the tensions that exist between health care workers and patients seeking care in emergency rooms, all with a view towards measurement not just of the quantitative—how long did it take?—but also the qualitative—how was the experience?

Substitute care in other environments is a big part of the process to reduce wait times in hospital emergency rooms.

Mr. Lou Rinaldi: I just wanted to add a comment from the riding I represent about the discussions I had on that issue with some of the folks who exercise the need of those emergency rooms. When you look from, say, the last four and a half years I've had the privilege to do that, one of the things that very commonly comes out is that when folks go to the emergency room, it is because they need it, so the expectations are very high. If the outcome is favourable, it tends to be, "Everything worked out great. We're happy," if you waited whatever the wait time was.

It's unfortunate that in many cases—professionals don't have a magic wand—it takes longer or maybe not, and that's the case. I agree with you that we need to help to deliver the more compassionate message for folks to understand, that it's not just the next person in the line and move on. I think that's a challenge. In general, I can tell you that at the three hospitals in my riding, the wait time for emergency is vastly improved, but we do have a lot of things to talk about. I just thought I'd pass that on.

I just want to switch course a bit, Minister, with aging at home. I can tell you before I ask the question that that's one of the things that's resonated so well, I guess not just within my riding but with anybody I talk to in the province. I have an example from personal experience: I had the unfortunate loss of my father about a year and a half ago. I have an 83-year-old mother. They lived together all their life, and her biggest fear was: "What do I do now?" We're very fortunate. She lives with my sister now and everything is great. But that was in the back of her mind for about a year after my father died: "What are my kids going to do with me now? Where am I going to go?" She has a couple of other brothers; it really plays, I would say, a mental game. They have time on their hands to think of those things.

I guess what I'm trying to say is that the folks I spoke to about this are just thrilled. We need to do a good job as we roll it out. My question is, as we roll out the aging-at-home strategy in the direction that we've taken—we talk about the bigger picture, but I wonder if you could spend some time on how you see the vision of this rolling out and how it's going to impact these folks. I'm going to use my mother as an example.

Hon. George Smitherman: Many of us have aging parent experiences. My experience around this was shaped by some seniors whom I ran into very shortly after becoming Minister of Health. I was talking to them about long-term care, and they lined up at the microphone one after the next and said—I'm paraphrasing, but it came across to me like this: "Listen here, sonny boy: Maybe some of us will end up in long-term care, but don't make assumptions as a health care system that that's our destiny. We live independently in our own homes now, and that's the place we know and love the best and where we intend to see out all of our days. What are you going to do to help make that happen?"

Home care is part of that response, and over the last four years, I think home care has grown by about 50% and I think 100,000 additional Ontarians are receiving home care.

What aging at home is about is leveraging the capacity of communities to help to provide services which reduce the barriers to people being able to stay in their home. Some of it's about health care services, for sure. Home care has grown to become far more sophisticated in terms of the range of things that we can do. We support people with palliative care to pass on in their own homes. That's very complex care.

Aging at home is also about, as I mentioned a second ago, reducing barriers. I'll give you one example. I had a chance a couple of weeks ago to be at the Chrysler plant in Windsor, where we're purchasing 100 Dodge Caravans. We're going to put those on the road all across the province of Ontario. That's going to give us the capacity do 135,000 additional drives to appointments. One of the things that your mum might need help with to be able to stay in the home she knows is to get to that appointment.

Shopping, snow shovelling, bathing, light maintenance, installing grab bars—very small things in the grand scheme of things, relatively inexpensive to deliver, but essential if we're going to have a formula which allows people to remain in their homes.

Aging at home will launch in the next 10 days. It will launch as a program this year with about a $100-million budget. It will grow over the next two years to be a $400-million-a-year program. It's $1.1 billion in brand new funding over the next four years. It's going to support hundreds of distinct initiatives, many of them engaging the capacities of communities like we never have before—ethno-cultural communities, parish nursing. Wherever people find community, we see an opportunity, with a modest amount of government resources, to leverage the mindset and the voluntary capacities of those communities to reach up and to assist more of the folks with the kinds of things that they need, which makes that

formula of the desire to stay at home much more possible.

Mr. Lou Rinaldi: The expectations of that particular service delivery for those folks are very high. I know that it's going to benefit a lot of those folks like I just mentioned—my mother. I know that it bothered her physically and mentally. We'll certainly look forward to get that rolling out.

How much time do I have, Chair?

1620

The Chair (Mr. Tim Hudak): Still about 10 minutes or so. Sorry, my mistake: seven minutes.

Mr. Lou Rinaldi: That's fine.

Minister, I just want to talk about doctors who are not practising. We hear all sorts of numbers about orphan patients. We hear all sorts of numbers about doctors out there. I guess the question is: Can you tell us how many doctors are practising in Ontario today?

Before you answer that, I'll also give you a report—I refer to my riding again. I was in Campbellford about a month ago—I know you've visited Campbellford, Minister—and they have a fantastic family health team. It's grown in leaps and bounds. I met with a nurse practitioner during Nursing Week—actually, I wore a gown for a few hours—and the response has just been phenomenal. The family health team operates just across the road from the hospital, and I meet with the hospital CEO and chief of staff on a regular basis. They tell me that it's taken quite a load off of their emergency room, because it's a small rural hospital and they've got limited resources and capability. They are just thrilled.

The other piece—although it's partially out of my riding, Minister. We talk about primary health care or delivery. I think I mentioned this once before: that about a month ago I was at the air base in Trenton, and the family health team there from Prince Edward county, which is in Leona's riding, is doing some wonderful work to catch some of those orphan patients. As you know, the Trenton air force base, 8 Wing-Trenton, is the biggest air base in Canada right now. There are a lot of new families and there are a lot of families without a physician, but they absorbed 600 orphan patients as a first round.

I'm just reporting what's happening out there, but I'm going to go back to the question: Can you tell us the number of doctors we have practising in Ontario, and where we've been and where we're going?

Hon. George Smitherman: Let me link the two different items that you brought up: the number of practising doctors and the number of people in the province of Ontario who are still in search of care. In the fact book that we handed out before, there's some good data from HealthForceOntario. Of course, as I mentioned yesterday, very often the data sets lag a little bit; it's very hard to have real-time data. But the progress in the number of doctors in the province of Ontario is pretty good, especially when you consider that we've also substantially increased the size of our medical schools and our residency training programs. So even though we already have evidence showing more doctors just in the last few years, we also have a production line of physicians that is growing substantially as well. In 2003, we had 21,472 doctors; in 2006, 22,725. And we're going to continue with our efforts to enhance the supply of physicians.

The great news is that because of additional physicians and initiatives like our family health teams, doctors have taken on 637,000 additional patients since April 2004. As a result, the Ontario Health Quality Council has said that the number of patients, based on sophisticated modelling, who are actively looking for care is about 400,000. When you consider that, just a few years ago, people were saying things like 1.6 million, 1.7 million, I think it shows the kind of progress we've made.

The exciting part is that in our platform and in our budget is the opportunity to build more family health teams. We have 28 community health centres that are still coming to life. We have 50 additional family health teams—I think I said that. We have 25 additional nurse-practitioner-led clinics. And doctors last year: 83% of doctors in Ontario took on more patients—on average, 50 patients each.

With all of these things combined, we really feel very confident that that number, which we've whittled down to 400,000—I say "we," but through the collective efforts of the people on the front line of health care—that getting family health care for all is a goal that is within reach for our province. Just a few years ago, it really seemed quite insurmountable. And the production line of more physicians will be very helpful.

The IMGs—just one small point: Last Friday, we had a chance to have a bit of a ceremony. There were 135 international medical graduates who completed all of their training—fully licensed, out into the communities. They were headed to Dunnville and St. Catharines. They were going to Oshawa and Barrie—all communities where the need of some of those unattached patients is well known. There are 630 more foreign-trained doctors right now in residency training in the province of Ontario, not to mention the massive expansions that we've made in the size of our medical schools. The production pipeline for physicians has grown substantially, and we're gaining confidence about our ability to get care to all those people who are looking for care.

The Chair (Mr. Tim Hudak): Thank you, Mr. Rinaldi. Minister, thank you. That does conclude the time for that rotation.

The official opposition for 20 minutes. Mrs. Witmer.

Mrs. Elizabeth Witmer: I remember well being the minister and sitting on that side of the House and having all of my colleagues ask me questions that could demonstrate how well the government was making progress. Anyway, it's now up to me, I guess, and the NDP and my colleagues to hold the government to account.

I'd like to begin by asking the minister to provide us with the names of the hospitals that currently have deficits. I do this because in the estimates of October 4, 2004, the minister said that "unfortunately, for the past

few years, Ontario hospitals have been careening down a dangerous slope toward unsustainability." He went on to say: "We have also made it clear to our hospitals that the era of deficits followed by bailouts followed by double-digit increases, year after year after year, has to come to an end. We have given our hospitals 18 months in which to get their budgets under control." You said, "We'll help them accomplish it."

Here we are in 2008, which is beyond 2006. I think we know that hospitals still have deficits, and I'd like to know how many and which ones have deficits. How much is the deficit? Then I'd also like to know what the government is doing to help these hospitals balance their budgets. At the same time, Minister, you indicated that you wanted to ensure that, as they were asked to balance their budgets, the quality of care not be threatened. So who has a deficit? How much is the deficit? And what is the government doing to help them balance their books?

Hon. George Smitherman: Firstly, if you read that quote back to me one more time and let it really sink in for everybody, they really would realize, through the efforts that we've made, the sea change that has occurred in the way that hospitals run their affairs in the province of Ontario. Bailouts are a thing of the past, double-digit increases are no longer the norm, and by legislation, hospitals are obligated to balance their budgets—in certain circumstances, over a two-year period, if that's what's necessary to address some in-year pressures.

I can tell the honourable member further, as I had a chance to mention at our committee meetings earlier this week or last week, that the last consolidated report we have of all hospitals in the province of Ontario was not a report about deficits; it was that hospitals had a combined surplus—I think at the end of the 2007-08 fiscal year, but the deputy will correct that if I'm wrong—of $282 million. We can also demonstrate with a variety of data sets the increase in the number of employees who are working in the health care environments. I don't believe it is possible to produce a list of hospitals that have deficits. I don't know that such a list exists, because the law that is on the book obligates those hospitals to find the necessary steps to get their budgets in accordance with that law. But I will ask the deputy if there's a different way to go at that question and whether it is possible to produce the information that you're talking about.

I just remind you, as we had a chance to talk about it in estimates the other day, that it used to be at the end of the year that you heard about a deficit. All this talk about deficits that you like to promote is from hospitals in the first week of the fiscal year saying, "We have a deficit for 12 months from now." I think that's just a really strong example of how the conversation has changed. You were in the habit of, very regularly, at the end of the year, sending hundreds of millions of dollars to hospitals as bailouts, and this practice has been substantively reduced. In a few circumstances in-year in the hospital environments, with some special circumstances in mind, there's perhaps a little bit of additional assistance, but not a budgetary free-for-all such as existed when we first came to office.

1630

The Chair (Mr. Tim Hudak): Deputy?

Mr. Ron Sapsford: Yes, thank you, Chair. We don't have a current list of hospitals with deficits. I think it's linked to your question yesterday, Mrs. Witmer, about hospitals with signed accountability agreements. Some of them have completed that discussion with the LHINs, and in those cases where they're signed, there is a plan for balanced budgets. Some of the ones that remain unsigned—and we're getting that information for you now—are still unsigned because the discussions with those hospitals and their particular LHIN are still ongoing. Until that discussion has been completed, it will be difficult to give you a quantitative answer to your question. So given the work that LHINs are now doing with that plan over the next two years, that's where the discussion is now taking place.

Mrs. Elizabeth Witmer: I hope that we are prepared to be honest and transparent, because if you can't produce a list, I will tell you that I certainly can produce a list of hospitals with deficits. I will also tell you that accountability agreements have been signed by hospitals with deficits. I know that some hospitals do receive money under the table just to move them forward and make it look like they've balanced their budget. I guess it really concerns me that we're not being honest—that we can talk about all the good things in the system, but the reality is that hospitals today are stretched to the limit. We continue to have deficits—the LHINs are well aware of who has deficits—but I'm not sure that anybody is taking a look at how those deficits can be addressed and how the budgets can be balanced. I could name hospitals in here, which I'm not going to right now, that have had deficits the entire time that the Liberals were in office.

I don't see much of a change happening as far as deficits are concerned. I think they're better concealed, because you can now use the LHINs as an excuse for not having the information, but believe me, I could give you a list right now, and that's what I'm asking for. I want to know how big the deficits are, and I want to know what plans there are either for debt repayment or balancing of these budgets.

We have to be honest with the people of Ontario. We have to make sure that hospitals continue to provide quality care. I hope that I can get an answer to that particular question.

Hon. George Smitherman: I'll accept the offer from the honourable member to produce the list of deficits, and we'll cross-reference that against what we have. If you want to share that with us through the clerk, we'd appreciate it.

I find your use of language—"under the table," "concealment" and "be honest"—to be a little bit at odds. The consolidation of hospitals at the end of a fiscal year is a measure that is obligated by accountants etc., and it showed that the net was nearly a $300-million surplus in Ontario's hospitals. That's not concealment; that's very transparent. It's a very honest reflection, based on rules set in law by accountants and the like. I don't really think

it's appropriate to use that fancy language when there are mechanisms which clearly showed that hospitals, at the conclusion of the fiscal year, had an accumulated surplus of nearly $300 million

Of course, in individual cases, there are hospitals that have to do work to get on-plan. At any one time, there are 10 or 12 that may need some work. But if you want to share that list which you've said that you have, we'll cross-reference that against what we know, and that will be helpful in informing all members of the committee. I appreciate your offer to give us that.

The Chair (Mr. Tim Hudak): We did have a commitment, though, from the ministry and from the deputy, to answer Mrs. Witmer's question to the best of your knowledge.

Hon. George Smitherman: Oh sure, yes.

Mrs. Elizabeth Witmer: I guess you've indicated that they have a cumulative surplus, so obviously it has been added up and obviously there is a list of those that have deficits and the amount.

I'd like to turn now to long-term care. We know that the people who are currently residents in long-term-care homes are there, and the conditions that they have are such that there are often more complex health issues. They're often more physically aggressive than in the past. They are people who have dementia, and they have some other form of cognitive impairment.

I know that there was an internal report done in 2006 outlining the models of care needed for these patients who exhibited aggressive behaviour in LTC homes. There has been some concern amongst the homes that there aren't any changes or recognition of that fact. I guess I would ask you, Minister: How do you plan to deal with those residents? The numbers probably are going to increase in the future.

Hon. George Smitherman: I don't think it's fair to say that cognitive behaviours and dementia have only emerged in the last four years. I know that's a premise that you like to build on as an excuse for why you eliminated all standards in long-term care.

There were standards when you came to office, minimum standards of care. Your party eliminated them all: no two-baths-a-week minimum, no 24/7 RN, no daily minimum standard, none. You took them all away. Even the NDP ones weren't very enforceable, but they at least had them, and you eliminated them all.

We're in the midst of restoring them. At the heart of our focus in long-term care is more staff. We have almost 6,000 additional staff in the long-term-care environment so far, and with investments that we have planned through our budget documents, we anticipate adding about 5,000 additional staff to the long-term-care complement.

In addition, in part through responses to the Casa Verde incident, which I believe occurred while you were the Minister of Health in 2001, a variety of initiatives have been undertaken particularly around enhancing the training associated with the provision of supports for these more frail and needy members of the long-term-care-home community. At the heart of it, our obligation with respect to those most vulnerable residents is to get more care into the homes.

We've added thousands of additional workers so far, and our strategy will be to continue to do. Just for reference's sake, right now there are 1,200 registered practical nursing positions being added to the long-term-care complement, and in the course of the next three years, we have 2,500 additional personal support worker and 2,000 additional nursing positions, which will supplement those 6,000 or so that are already there and all-total will represent millions and millions of additional hours of care for long-term-care residents.

The deputy may have some further information to offer with respect to initiatives in the long-term-care environment, or perhaps you have a follow-up.

Mrs. Elizabeth Witmer: Do you know what? I'm sorry that I didn't hear an answer. I simply asked how we plan to deal with these patients. We all know that the situation is going to get worse. It doesn't matter which government or which minister is in charge. We just know that the number of physically aggressive residents with dementia or some other form of cognitive impairment is going to increase, and those with complex conditions as well.

I would ask you, since there wasn't an answer there, and we know that there was an internal 2006 expert panel report outlining the models of care that were necessary to deal with these patients, if you could provide us with that report.

Hon. George Smitherman: I'm not familiar with the report. I'll ask the deputy to work with the ministry to determine what that is. An unnamed report in a given year is not familiar to me.

You said you didn't hear an answer. Let me try again: more staff; more training; minimum standards, which you eliminated; and capital renewal. I think that the B and C renewal, an issue that you've spoken about quite a lot, is one part and parcel of creating environments which are more suitable for people who are experiencing dementia.

But really at the heart of it, the single most important of those strategies is to have more well-trained individuals providing care in those environments. That's the number one strategy.

The Chair (Mr. Tim Hudak): Is the deputy aware of the report that Ms. Witmer has referenced? If not, we can solve this outside—

Mr. Ron Sapsford: I can guess. I think it's a follow-up report to the coroner's inquiry, but I'll clarify that.

1640

The Chair (Mr. Tim Hudak): Thank you.

Mrs. Elizabeth Witmer: You referenced Casa Verde and the inquest. It's come to our attention that, regrettably, the government has failed to implement most of the recommendations stemming from that inquest. I just wondered if you could provide us with a list of the recommendations that have been implemented and also a

list of the recommendations that remain to be implemented.

Hon. George Smitherman: Yes. Of course, we'll bring together what information we can and we'll see if that report that you're referencing is perhaps related to that inquiry. I'll be happy to do so.

Mrs. Elizabeth Witmer: I appreciate that.

I'd like to move now to the long-term-care homes. Regrettably, the population is aging, and there are more people who are looking for access, particularly in certain parts of Ontario. The 20,000 beds that we had announced in 1998 are no longer responding to the need 10 years later. What numbers of individuals are on wait-lists for long-term care in each LHIN in Ontario? We know, for example, that London had a very serious problem. If you could provide me with a wait-list for access to long-term-care homes—not for each home; obviously, now it's the LHIN—I'd appreciate to see what the waiting list looks like.

Hon. George Smitherman: What we'll also do is—we're working on getting you that list that I referenced top of mind of those expansions, the additional long-term-care homes which are being built.

You mentioned London. Specifically in London, we have new long-term-care homes being built: Henley Place, with 192 beds; Oneida Nation of the Thames, with 64 beds; the Homewood Corp., with 192 beds; and PeopleCare, with 160 beds. So I defiantly agree that London has been an example of a community with some particular challenges. In your home community—in the region of Guelph, there's a substantial investment of new beds being built in Guelph as part of about 2,500 additional beds that are being built.

We'll get you that whole list and also seek to bring together the data that you requested with respect to what—I think they measure it by median wait time or something like that—the progress to admission is in a long-term-care home environment. Also, just a reminder: The alternate-level-of-care announcement that we made as part of our ER announcement from 10 days or so ago really raises the caps that were in place for quite a long time—I think initiated by your government. We've eliminated those caps so that individuals who are in a hospital might be able to go home with a greater degree of support from home care. So we're also seeking to maximize the capacity to provide support for people in the home environment and, indeed, for people who are at home but at risk of heading to a hospital or seeking transfer into long-term care.

We're also creating more flexibility for the CCACs to enhance their levels of care, to provide a higher degree of support so that people can remain in their own home. That's a complementary strategy. We'll happily get you all that data on the long-term care.

Mrs. Elizabeth Witmer: We look forward to seeing the actual details on that announcement. The announcement was certainly very helpful. I guess now it's a matter of seeing what impact it's going to have on different communities. I hope that you'll invest in Waterloo, because I'm not Guelph. And we do need that other MRI.

Hon. George Smitherman: Firstly, I didn't mean to make a mistake, to refer to that as the same region.

Mrs. Elizabeth Witmer: I know; I'm just teasing.

Hon. George Smitherman: But I do know that there is some sensitivity. Perhaps it's because the member beside you is so frequently a visitor in Guelph.

Interjection.

Mrs. Elizabeth Witmer: He tells me he's not Guelph either.

Hon. George Smitherman: He's not Guelph either, no. But I do tend to see him at announcements in Guelph quite a lot.

With respect to the MRI, that's the Cambridge issue that you were mentioning. One opportunity that we are pursuing in shorter order is that the not-for-profit MRI that's set up in the community may have some additional capacity that we can take advantage of quite quickly. We're currently assessing whether we would have the resources to give more access to those residents in Cambridge experiencing too long a wait—whatever capacity we can find in the broad Waterloo Wellington Local Health Integration Network area.

Mrs. Elizabeth Witmer: At the not-for-profit one?

Hon. George Smitherman: That's right; the one that has had its status revised.

Mrs. Elizabeth Witmer: Right. I'm quite aware of and familiar with it. Thank you.

The Chair (Mr. Tim Hudak): You have time for probably one more question.

Mrs. Elizabeth Witmer: Okay. Maybe we won't finish it. Anyway, you mentioned the rebuilt beds. There's a need, as you know, to rebuild 35,000 of these beds over the next 10 years. You've said that you would. We're now into a year later since that announcement. I'd like to know how many of those beds have actually been started—in other words, shovels in the ground.

Hon. George Smitherman: It's not really accurate to say that it's been a year, but it certainly has been about eight or nine months. We're working on the policy development work through the summer. No announcements yet in terms of the go-forward for the first tranche, but we anticipate doing 3,500 beds a year for 10 years. Towards the end of this fiscal year would be the first opportunity to move any of those projects forward. What we have said is that the local health integration networks will play a role in helping to prioritize which beds are most in need of redevelopment.

We also have to be mindful—because you would know very well that as we move to the new standards, the homes are much larger. They're not all going to be accommodated on the sites where they are. In some cases, there may be a desire to bring the beds of two homes together onto one site. So we think it's important as well that the LHINs, with their more localized perspective, be involved in helping to resolve some of those issues.

Certainly in this fiscal year, the policy work, the policy approval work, the consultation with OANHSS and OLTCA would be ongoing as we seek to shape a program. There's a rest home you may be aware of in Zurich, the Blue Water Rest Home—in Carol Mitchell's riding, I think. It has been an example of a home that has—it's one of those blended ones. It's got some Bs and some Cs.

Mrs. Elizabeth Witmer: Yes, I do know it very well.

Hon. George Smitherman: They've had a dickens of a time trying to get their home into redevelopment. We've really gotten down into the detail with them and tried to unlock for those small homes in the most rural parts of Ontario which are so essential—and big employers—to make sure that we can find models that work well for them. That's going to inform the work that we do on the B and C redevelopments.

The Chair (Mr. Tim Hudak): Thank you, Minister.

Interjection.

Hon. George Smitherman: Okay. So you know what a pleasant place it is. I forgot that that's close to Exeter.

The Chair (Mr. Tim Hudak): Thank you very much. Time has expired.

Madame Gélinas, you stacked your time so you have 40 minutes.

M^me^ France Gélinas: I'd like to start with a quick question on hepatitis C. The Ontario hepatitis C assistance plan was set up to provide financial assistance to help hep C victims outside of the 1986-90 window. I believe that $200 million was set aside to compensate these individuals, and 3,700 who qualified received the $27,000, which your ministry confirmed left $108 million unspent. Does the minister plan to contribute the three elevenths to the pre-1986/post-1990 federal compensation, as the Ontario government has done for the 1986-90 class-action hepatitis C victims?

Hon. George Smitherman: I don't understand—contribute the three elevenths?

M^me^ France Gélinas: When the federal government came out for the 1986-90 victims, this segment got three elevenths more than the people pre-1986/post-1990.

Hon. George Smitherman: I'm going to let the deputy or perhaps an individual from the ministry offer more information here, but I think one thing that needs to be addressed forthrightly is the $200 million.

I think the initiative of the provincial government at the time was one that all members of the Legislature supported. To witness people with hep C divided up into classes and having differing circumstances for differing years was a very painful and torturous thing for many individuals. The $200-million fund that was established was based on a projection that never came true in terms of the number of people. I think there's been a lot of misunderstanding about that.

A year or two ago, I believe the auditor—and the deputy can correct me if I have this wrong—wrote down the amount that the province was holding back, because you could see by the projections falling short—i.e. the number of people who were projected to have hep C being much higher than the number of people who actually met the criteria for the program—that the entire $200 million was not going to be required as it was initially intended. Through the contributions that Ontario made proactively—and you will recall that they increased the amounts already one time—it's my understanding that those Ontario residents received a benefit that was equal to or greater than the implication of the federal settlement, keeping in mind that not all provinces had taken the steps that Ontario had at that point.

That's some information that I have. I'm not sure whether the deputy can offer any more or perhaps take under advisement somewhat the question and try and get back to you with some additional information as it relates to that federal settlement.

1650

I've been around this health thing for four and a half years, and I don't think there's a more complex file and a more misunderstood file than this hep C one, to be honest with you. So I would want to be very cautious about the way that the information is put into the questioning.

Mr. Ron Sapsford: I'll have to get back to you on the specifics. I can tell you that the program that Ontario funded was substantially different from the federal settlement, with a different group of people. The notion that the difference between the two plans is simply closed by another payment is a misinterpretation of the plans. But I'll get the specific information for you.

M^me^ France Gélinas: Okay.

Before I get into home care, I have a quick question on PET scans. I, like every other MPP, have received many letters and e-mails from Ontarians concerned about access to PET scans in Ontario. We are asking your government to extend access to PET scans and that they be covered.

I understand that since 2002, the ministry has funded five clinical trials and that the Ontario PET screening program has recommended one more pilot study in addition to the cancer PET registry study and the cardiac PET registry study. I also understand that Ontarians hoping to access PET scans can apply to the Ontario PET access program and have their application reviewed on a case-by-case basis by a clinical expert in order to determine whether a PET scan would be appropriate.

So my questions are as follows: Can the minister explain why some of the trials are taking over six years? How many people apply for access to PET scans and how many actually get approved? Once those trials are completed—first of all, when do you expect them to be completed and when do you expect the decisions to be made?

Hon. George Smitherman: Those very specific questions—I'm going to let the deputy assist in giving you some further information. Two or three things that I think are important to say: Firstly, I see the anguish in a lot of the requests for PET scans, and I believe that some people are being offered PET scans as some panacea, at a late-stage circumstance or what have you. This is a very expensive technology, and it's a technology that's going

to be more effective in a relatively narrow band of clinical circumstances. I have to say very directly that Ontario will not be in a position to implement PET scan technology across the province without very strict clinical guidelines about the circumstances where that can be useful, because it would be easy to spend $50 million or $75 million a year and get very little clinical benefit from it.

The work that's going on with what I would refer to as a pilot, these clinical trials, which other jurisdictions like Australia, as an example, are watching to see what the information—it's designed to inform us about where the PET scan can be particularly effective.

There are specific answers that we'll get for you, but I have to be very candid with you on one other point: In our budget, as it's presented now, in the future-year outlook for our budget, I do not have an embedded line that projects substantial growth in expenditure related to PET scans. Part and parcel of this is what I just mentioned a second ago, and also the obligation that we have, which is that we have existing diagnostic capabilities like CT scanners and MRIs. It has been a big focus of ours to make sure that access to those—already deployed, but unequally so—is universally good. That has been a big focus for us.

I'm not sure if the deputy will have some information at hand or if he might want to get back to you with some answers to those very specific questions that you posed.

Mr. Ron Sapsford: I can add some of the details in terms of numbers. There are five areas of clinical trials: one in the area of lung cancer, one in breast cancer, head and neck cancer and metastatic colorectal cancer. The trial cohorts were set up in a way to parallel specific clinical conditions where the cancer experts felt that PET would be of some use in providing a differential diagnosis. So for some examples, in the head and neck cancer cohort, the target enrolment for that particular subset was 400, and as of the end of March 2008 the enrolment has been 328, so we're approaching the target enrolment. For stage 3 lung cancer, that cohort was targeted at 400, and as of the end of March it's 268, so there's further to go. Another example would be in cancer of the lung—single pulmonary nodules and a number of clinical indicators. The original target enrolment was 600, and as of March 31, 2008, it's 1,410. So that particular cohort has completed its review.

The process that's used is, when the cohort number has been reached, there's a review done by the experts, then decisions made about continuing clinical access, where we move from a clinical trial into a registry. For several of the groups, we're now at a registry stage, so that where the clinical condition presented by an individual patient fits the criteria, the PET scan is provided automatically.

I think that's important to understand. The restriction is not, "You can't have a PET scan"; it's rather, "Does the clinical picture present that requires the differential that the PET scanner can bring?" All of these are moving forward. Some of them take longer than others because it's a question of identifying individual patients and getting them through the process.

M^me^ France Gélinas: I'd like to move to home care. There's no page number, but it's the document you gave us on the first day. It has a fact sheet on increased access to home care where it shows $1.79 billion for 2008-09 and $1.68 billion for 2007-08 for home care. I was wondering if I could get a breakdown of those expenditures by what I call clinical line—as in nursing, homemaking, therapy—to have an idea of the $1.68 billion for last year. Actually, I would like it for all the years, if you could, starting in 2003—how much went for nursing, homemaking, therapy and case management. I don't know if you're also able to tell me: Of those, how many were delivered by for-profit versus not-for-profits? Let's say we take nursing—

Hon. George Smitherman: They're delivered by regulated health professionals or other people. I'm not sure that we put a label on them like that.

M^me^ France Gélinas: Usually the CCAC will have a contract with an agency. Let's say they have a contract with VON to deliver so many courses of care in nursing. Let's say for nursing in a specific CCAC: Can we find out if those contracts for those many hours of nursing were given to a for-profit or a not-for-profit accredited service deliverer?

Hon. George Smitherman: If we have that data, yes, absolutely; I don't know if we do, but sure.

M^me^ France Gélinas: And for the data, to know—I'll take the $1.68 billion because I realize that 2008 hasn't gone by yet. Can we find out how much went to a contract for nursing versus home support? Is this something that is feasible to find out?

Hon. George Smitherman: We'll have to look and see how they pull it apart.

Mr. Ron Sapsford: I just don't know how it's organized, but we'll do our best to bring forward what information there is.

M^me^ France Gélinas: As I said, when you do look, if you can find out how many of those contracts were given out to for-profit versus not-for-profit over the years, that would also be helpful.

I then move to the second little square, which talks about the number of Ontarians receiving home care through CCACs. We saw that in 2006 there were over half a million people. That's a lot of people: 535,000 people. Can we have this broken down by how many of those 535,000 people were receiving nursing versus how many were receiving homemaking? Is this something that we can get?

1700

Hon. George Smitherman: We're making note of all the questions, and we'll do our very best to compile it as you've requested it.

M^me^ France Gélinas: All right. Then I was most fascinated by the lower box on the right-hand side. I have no idea how you calculate this and where the data comes from to get this. This is, "Hospital visits prevented."

Hon. George Smitherman: I'll have to try to understand where they're coming from in terms of the use of the word "prevention" there. We'll definitely get you an explanation about what these numbers represent.

M^me^ France Gélinas: We seem to have been tracking this for the last four fiscal years, anyway.

Mr. Ron Sapsford: There are some codes in hospitals like ambulatory care visits diverted to other providers, and there are probably some categories where days of admission have been reduced as a result of the home care. But we'll find the—

Hon. George Smitherman: I know where it flows from, or I'm pretty sure. It flows from the accord which was reached in 2003 as part of the response to Romanow, where the federal government dedicated some additional resources to provinces to enhance home care services. It was all about substitution of acute or preventing hospital stays and the like.

We'll get you the rationale for that, but I know that's where it's coming from. That was a big thrust of what's referred to as the accord, and I think that was struck in 2003 quite soon after we came to office and profiled those investments around palliative care, mental health, post-acute support etc. We'll try to unlock a little more of the rationale behind those numbers.

M^me^ France Gélinas: When we look at home care, is there any way, either through the number of Ontarians receiving it or through the expenditure, to track how many of those hours are provided by full-time versus part-time staff, or am I dreaming here?

Hon. George Smitherman: I think that's going to be quite difficult, but we'll make a note of it, and if there's anything that we think is helpful or relevant to that line of questioning, then we'll supply you with whatever we might be able to find.

M^me^ France Gélinas: Okay. That's it for those three boxes.

The next one also has to do with home care, but it has to do with the maximum. I followed the announcement, and I was very happy to see that the maximum hours of home care were going to be increased in general, and then special allocations were done for people on palliative care, ALC and post-discharge from hospital etc. I'm more interested in asking: Is there a line in your budget or is there a will from your ministry to remove the maximums and fund health care on the actual needed hours rather than having a maximum set for different categories?

Hon. George Smitherman: If you're asking, "Is it possible to revert to a situation in health care where any organization can spend whatever they want in a year and at the end of the year just give a bill?", I'd say no. Obviously, what we create is an additional funding resource for community care access centres and, through enhancements of the rules, more flexibility and discretion on their part to attribute resources towards a goal. A goal, as an example, of keeping an individual in their own home rather than seeing them end up in a hospital headed towards long-term care means that the CCAC would have greater flexibility to give that individual an enhancement in care.

M^me^ France Gélinas: That's not quite my question. I realize that the maximum used to be 60 hours. You have bumped this up to 90 hours recently for chronic home care clients. Is this a trend where we will see at some point that there will not be a maximum and it will really be the case manager who will decide based on the need?

Hon. George Smitherman: I think it might be helpful, Deputy, if you might get someone to speak more specifically to this. If an individual is waiting for a long-term-care bed, there's no maximum at all.

M^me^ France Gélinas: I want this for everybody.

Hon. George Smitherman: That's the open-ended circumstance. I have to say, practically speaking, that no, we'll still expect community care access centres to operate within the allocated budgets. Their budgets have gone up pretty substantially. Does it mean that it's a free-for-all and that every hour of requested care will be made available? No. It's a substantial improvement. There's greater flexibility and it offers some discretion to the community care access centre to offer substantially enhanced supports, but still operating within the budgetary allocation that's available to them.

Mr. Ron Sapsford: Yes. I think what we're trying to attempt here is to maximize the use of home care for as many people as possible so that the number of patients who require the maximum amount of care in a month is on the smaller side than the average person who requires home care, say after surgery, and going home. The idea here is to provide the maximum flexibility for CCACs so that discharges from hospital, either in terms of the amount of care on a daily basis or for the length of time applied, are given the maximum amount. But as the minister said, that's still within an allocation that's worked out with each CCAC. The monies for that change are provided in this year's estimate, in vote 1411.

M^me^ France Gélinas: Okay. We all understand that there is a moratorium. Since the Hamilton CCAC, there have been temporary guidelines from the ministry to extend existing nursing contracts and not issue new tenders for a request for proposal. That has been in place for about four months now. Are there new guidelines being issued that say that contracts can now be extended for another two years? Is there any new guideline issued by your ministry lately on this?

Hon. George Smitherman: I'm not sure about the use of the word "new," and I don't know about the word "guideline." It may have a specific meaning that I'm not conscious of. But certainly the government—I'm still doing some work that I will take through the process in terms of what alterations we might make to the nature of the competitive bidding process for the purposes of the provision of home care. We have given direction to community care access centres to extend their existing contracts. They have lots of capacity to do that. We've done it in many instances over the last few years.

We saw the way that events were unfolding in Hamilton and Brant. The process had not served people

as well as we would have hoped. We felt that on the early evidence—and it was very early evidence—there was an opportunity to stop the trains and to take advantage of a little bit more time to consider what was happening there.

I'll just give you one small example. We had a long-standing provider in the Hamilton community that was thrown out of the process because they didn't do the paperwork well. There might have been other compelling reasons, but we just really felt that a long-standing provider ought to have the opportunity to complete the entire process. This is just one example of some of the evidence that was available to me that suggested that it would be appropriate to give pause and take a look at some of those things before we move forward. We're still in that period where we're considering that, as a government. As you've said, in the meantime we've given CCACs direction to extend existing contracts.

M^me^ France Gélinas: Can we have a copy of those directions?

Hon. George Smitherman: Yes, sure. I think it was just correspondence from an assistant deputy minister or something, but yes, sure.

M^me^ France Gélinas: Okay. Since wages and job security are less in the home care sector compared to the hospital sector or a number of other sectors, will the ministry act to fund a wage parity strategy for workers to ensure the ability to retain and recruit, especially nursing, but all the health care workforce in the home care sector?

Hon. George Smitherman: That's not in our plans and it's not embedded in the budget, no.

M^me^ France Gélinas: Not on the radar.

Hon. George Smitherman: It's on my radar, yes. I'm very conscious of it, for sure, but it's not an inexpensive matter to create parity across all of those sectors. I think it has much merit; absolutely. We have made strides, through the report from Elinor Caplan, to enhance compensation and benefits for personal support workers, but there's lots more progress that would be possible on those fronts. I would be frank in saying that it's not a funded initiative in the budget of the Ministry of Health that is before us for consideration.

1710

M^me^ France Gélinas: Okay. There's also some labour transition within home care, and in this, I'm talking about successor rights. Many unions say that the easiest way to implement successor rights within the home care sector is to enact the PSLRTA—I never know how to pronounce this—basically, the Public Sector Labour Relations Transition Act. Is it the will of this government that this specific act be applied to the CCAC RFP process?

Hon. George Smitherman: That has not been our policy, no.

Mr. Ron Sapsford: The PSLRTA will apply to integration decisions of local health integration networks. The statutory provision was included in the LHIN legislation but does not extend to this particular part of it.

M^me^ France Gélinas: And it's not the intention of this government to make it so?

Hon. George Smitherman: No, not at this time.

M^me^ France Gélinas: Because I ran out of time last time and I don't want that to happen to me again, I am going to be moving on to long-term care.

The Chair (Mr. Tim Hudak): You've got about 15 minutes left.

M^me^ France Gélinas: All right. I'll start with the paper you gave us. I'm on the fact sheet that's called, "Ontario Government Committed to Further Increases in Care in Ontario's Long-Term Care Homes." The funding for long-term-care homes shows an increase from $2.1 billion to $3.16 billion.

Is there an opportunity for us to have this broken down by envelope: long-term-care funded nursing and personal care, accommodation line, programs, support, food? Can those numbers be broken down in that way and shared with us?

Mr. Ron Sapsford: I believe so, yes.

M^me^ France Gélinas: That would be helpful.

Looking at the hours per resident—you won't be surprised; I've asked this a number of times. In 2008, you talk about 2.94 hours. We certainly don't come to the same—there are a couple of questions.

The first one is: Are the 2.9 hours solely the hours funded by the Ministry of Health and Long-Term Care? I'm thinking that municipal homes often fund, so is the 2.9 only the money that comes from the Ministry of Health and Long-Term Care?

Do you look at the difference between the paid hours and the work hours?

My third question is: Is the programming envelope in, or out, of those calculations?

Hon. George Smitherman: We talk about paid hours of care per day. I'm pretty sure that these are our numbers and wouldn't capture supplementary hours that a—

Mr. Ron Sapsford: It's all hours—the paid hours. It includes all hours of the home.

M^me^ France Gélinas: Okay, so if the home has other sources of funding, it would be included in the 2.9?

Mr. Ron Sapsford: Because they report all staff hours, yes.

M^me^ France Gélinas: Is the programming envelope in or out?

Mr. Ron Sapsford: In this number?

M^me^ France Gélinas: Yes.

Mr. Ron Sapsford: Included.

M^me^ France Gélinas: It includes it. And it includes paid? Okay.

I know that homes have to report on staffing information, but we also know that not all homes report on staffing information; there's always some, for some reason—I know this because we FOI'ed it, so I got the report back. When you look at 2.9, how do you account for those homes that have not reported their hours?

Mr. Ron Sapsford: These numbers would be based on total reporting and averaged over the homes. So these would be average numbers as opposed to anything else. The reasons for lack of reporting on a particular quarter could be varied. I'd have to look in more detail for what the specific reasons are, but one home out of several

hundred is not going to shift the average for the province in a great way. There might be a marginal adjustment depending upon an individual home.

M^me^ France Gélinas: So you feel confident that the homes that have reported are representative of all the homes?

Mr. Ron Sapsford: Oh, yes, of the vast majority, yes.

M^me^ France Gélinas: Okay.

Mr. Ron Sapsford: I want to correct the record. The programming—if you're referring to physiotherapy and those services, they are in addition to the 2.94 hours. This is really the nursing and personal care envelope, but it does include all nursing and personal care irrespective of funding source.

M^me^ France Gélinas: It's based on paid hours.

Mr. Ron Sapsford: Yes.

M^me^ France Gélinas: What is the annual funding for this fiscal year and next—no, sorry. That's not my priority for questions.

We've talked about investments in long-term care. Some of them are spread over a number of years. Could we find out how many are for this year, next year and the third year?

Hon. George Smitherman: How many people working in those environments?

M^me^ France Gélinas: Yes. You've made announcements for more nursing staff, more RPNs, more PSWs etc.

Hon. George Smitherman: The only one that we can say for sure—I can give you two. The one that did bridge two fiscal years is the 1,200 registered practical nursing positions. Those resources are flowing into long-term care, and the hours and staffing are being added at present.

For this year, we contemplate investment in personal support workers. I want to say 865, but I have a bit of a mental block. Is it 865 or 835?

Interjection.

Hon. George Smitherman: There are 865 additional personal support workers this year. There will be some allocation of additional nurses, but it's not yet landed.

M^me^ France Gélinas: Okay. I know that you've talked a bit about some of the regulations—

Hon. George Smitherman: Could I just say as well on those 865 personal support workers, for implementation—as of August 1, that funding will be available to the long-term-care environment for the 865 personal support workers. We're working with OLTCA and OANHSS to find the best way of making the allocations as we go forward.

M^me^ France Gélinas: So you don't have a set—let's say for the nursing staff, do you have a set target as to when you want all those positions to roll out?

Hon. George Smitherman: We want to roll them out as we can afford to pay for them. In a certain sense, budgetary allocation dictates when they can be implemented, but what we see is a pattern of investment that would take us to 3.25 hours of paid care.

M^me^ France Gélinas: Okay. I think I understand; I'm not sure. Let me think that through.

Hon. George Smitherman: Over the mandate.

M^me^ France Gélinas: So over the course of three years. But if I'm looking specifically for 2008-09, 2009-10—

Hon. George Smitherman: For 2008-09, I've given you the information where we've made those decisions which relate to the PSWs, with the first tranche implemented for August 1.

M^me^ France Gélinas: We've talked a little bit about regulations. One of them is the RN 24/7 regulation. Do you know how many homes have been in violation of the 24/7 mandatory RN regulation in the last fiscal year?

Hon. George Smitherman: I don't know if the word "violation" is 100% appropriate, because we did have to offer a little bit of latitude to some smaller homes that have had a difficult time being able to meet the test of that standard. But the deputy may be able to offer some additional information associated with it.

Mr. Ron Sapsford: We will find the answer for you.

M^me^ France Gélinas: If "violation" is not the right word, I'm ready to change it to whatever it's called, but—

Hon. George Smitherman: The only reason I say that is because I know that we had, by necessity, offered a little bit of latitude for some of those smaller homes. So they may not be officially in violation, even though they may not be meeting the RN test. But we'll do that research for you.

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M^me^ France Gélinas: I think you've already said that you will tell us how many of the Casa Verde recommendations you're in compliance with and how many are left.

Hon. George Smitherman: Yes.

M^me^ France Gélinas: So my next question is: Do you have any idea when the Sharkey report will be submitted to you?

Hon. George Smitherman: The Sharkey report will also be released. What we're working toward doing is creating a multi-stakeholder implementation team. Because of Bill 140, we have a lot of regulatory work that's ongoing. I have some phone calls to make to get all necessary stakeholders on board. We've never done this before. So we're going to try something a little bit different, which is to bring all of the parties associated with long-term care into the same environment—representatives of workers, representatives of families and residents, representatives of the operators of homes, responsible individuals from the ministry—with Shirlee Sharkey's report and her leadership helping to frame the go-forward, to try to create a consensus in terms of the content of some of the regulations. I don't have a date for you exactly, but it will be relatively soon.

M^me^ France Gélinas: Usually, you let form follow function, as in, you're talking as if you've seen the report and the best way to implement the report is to have this format. So have you seen the report?

Hon. George Smitherman: I've had a high-level briefing from Shirlee Sharkey on the report. I've not personally looked at it.

The Chair (Mr. Tim Hudak): Five minutes.

M^me^ France Gélinas: This man stresses me.

The Chair (Mr. Tim Hudak): I'm just trying to be helpful.

M^me^ France Gélinas: I'm looking at the service agreements in long-term-care homes. Why is there no longer any requirement in the service agreements that homes must use funding from their NPC hours per resident?

Mr. Ron Sapsford: Sorry, I don't understand.

M^me^ France Gélinas: There used to be a requirement that the funding to nursing and personal care had to be spent in nursing and personal care. This requirement is not in the service agreements anymore. I'm just wondering what happened there.

Mr. Ron Sapsford: I'll find out the specifics. It's very clear, though, that the nursing and personal care envelope is for that purpose and that purpose alone. So whether the words are changed or it's been incorporated, that's still the principle. And where it hasn't been spent for that purpose, the ministry still recovers those funds. But I'll check the specific request.

Hon. George Smitherman: This is probably not exactly the same thing, but somewhat similar: Last year, we initiated quite a big increase in the raw food per diem, and we rolled that out to all long-term-care homes. But we found later that some who were already supplementing the food and were at that $7-per-day level decided just to take the money. In speeches to both OLTCA and to OANHSS, I've been clear in saying that as we move forward, we will no longer be putting ourselves in a position where we're allocating the people's money toward a perceived improvement or benefit for residents, only to see any home eat that up and let it affect the bottom line. For-profit or not-for-profit, we're going to work more diligently to ensure that a dollar sent for an intended purpose gets spent on that purpose. I think that's sort of the principle of the matter at hand in your question. Whether they're related or not, I'm not sure, but I just thought I'd mention that.

M^me^ France Gélinas: Yes, it is related.

Right now, you're implementing a new data system into the homes. I realize that most homes won't report on both sets of data—the old system and the new system. Is there an update as to how the data is coming back from the new system that's being implemented in the long-term-care homes I'm talking about?

Mr. Ron Sapsford: Yes. We're in the process of implementation. I'll check the exact numbers, but I think that by the summer of this year there are an additional 45 homes going into the system. I think that by this time next year it will be completed. The information provided, of course, is—

Hon. George Smitherman: It's not that fast.

Mr. Ron Sapsford: It's not that fast?

Mr. John McKinley: Not that fast.

Hon. George Smitherman: I think Assistant Deputy Minister John McKinley, one of the longest-serving Ministry of Health employees, having recently received an Amethyst Award for long service and dedication, has a lot of institutional memory on this very point and might illuminate us.

M^me^ France Gélinas: Okay. Hi, John.

Mr. John McKinley: Hi.

The Chair (Mr. Tim Hudak): If you don't mind introducing yourself just for the sake of Hansard.

Mr. John McKinley: Sure. I'm John McKinley. I'm assistant deputy minister of the health system information management and investment division.

The Chair (Mr. Tim Hudak): Thank you.

Hon. George Smitherman: What is the acronym for that? Sorry, Mr. Chair.

Mr. John McKinley: We are in the process of implementing what is called the MDS 2 tool for classification of long-term-care-home residents in Ontario. It is a process that does take a fair amount of time because of the way we are doing it. We are introducing it on a home-by-home basis, and we are training people as we go through this process to bring them up to speed as to what value this has for the resident, the caregiver and the family. It is a process that we have under way that has taken us two years to get this far. We anticipate another two years to get to the end. We're learning as we go along how quickly we can implement it. We're about a little less than halfway through the process. Various homes are in various stages of implementation, so it's hard to say exactly how many have implemented it, because it is a very staged process.

The information that is coming back to us from this at this point is early days. We have what we've more or less characterized as a little bit more anecdotal information because it isn't broad enough yet to extrapolate out to the entire system, but we are getting some information back that is quite positive in the sense that it is a useful tool to the caregivers and providers of services and there is a requirement for ongoing support for it as it rolls out into the homes.

M^me^ France Gélinas: Are you confident that—

The Chair (Mr. Tim Hudak): I'm sorry; 40 minutes does fly. That concludes the time for the third party.

We'll go to the government side, and I think there's a commitment from the government to take 15 minutes in this round, so we'll end at 6 o'clock on the nose.

Mrs. Maria Van Bommel: I want to address with the minister the issue of supply of doctors. I know that we've made a lot of investments in increasing the supply of doctors. Certainly in my own riding I can cite a situation in a community called Newbury where that investment has allowed the community to go from being underserviced to actually escaping that designation, and that has been very important. It is a small community, but it has a very, very large catchment area, and as a rural community certainly—

Hon. George Smitherman: It has four counties, I heard.

Mrs. Maria Van Bommel: Yes, four counties, and it makes it a little more difficult to recruit and retain, so investments have certainly helped us out there.

But we also have situations of aging doctors. I know that we're going to be faced again with these types of situations in my riding, and we certainly have some of that still ongoing. I'd like to ask you a bit about when those investments—and I know that we've seen some results, but I certainly expect that there's going to be something in the future as well. If we could talk about that, please.

Hon. George Smitherman: Mr. Chair, I'd just like to re-introduce to the committee Dr. Joshua Tepper, assistant deputy minister, to answer questions about a production line for our physicians.

The Chair (Mr. Tim Hudak): Josh Tepper is an assistant deputy minister now?

Hon. George Smitherman: Yes.

The Chair (Mr. Tim Hudak): I remember when he was a medical student. Good to see you again. Congratulations.

Dr. Joshua Tepper: Thank you, Chair. It's nice to see you. Thank you, Minister.

Mrs. Maria Van Bommel: Now you've embarrassed him.

The Chair (Mr. Tim Hudak): Well, good for him.

Hon. George Smitherman: He's blushing.

Dr. Joshua Tepper: Yes.

The Chair (Mr. Tim Hudak): Sorry to interrupt. I'm just happy for you.

1730

Dr. Joshua Tepper: No, no. Thank you very much, and thank you for the question.

There have actually been a lot of different investments, and I'll share a few of the numbers, but I think, even more than the numbers, what would be important to hear is that it's not just about doing more but doing things differently that's really, really exciting and starting to show some really good dividends.

In terms of medical school numbers, we've gone from 692 in 2003—and these are numbers I will quickly type up—

Hon. George Smitherman: 692 what?

Dr. Joshua Tepper: —first-year medical students—to 852 in 2008. With the same base year of 2003, we have gone from 639 first-year residents to 951 in 2007.

I know that a really important source of physicians has always been international medical graduates. Again from 2003, where we had 271 international medical graduates in our training system, we now have 623 in 2007. To that 623, you can add—and growing—another 235 in 2008. So it's 235 this year, but we haven't closed our growth this year. I know our target was 200, but we've been able to exceed that by at least 35.

To look a little bit more at the specifics of your question about, "Okay, well, those are in training, but we know it takes a little while," how many are actually getting out into practice? Again in 2003, we were graduating 533 out into practice. In 2008—on July 1, actually, so just a few days from now, because medical schools and postgraduate runs on the July-to-July calendar—we will be graduating 783, including IMGs.

Again, with the minister and the deputy's permission, behind these numbers I think is a really important story. We're not just doing these numbers in the same way we've always done, but in a really different way. That includes doing it through satellite campuses across the province and a new Northern Ontario School of Medicine. Taking that northern Ontario school for a minute, this is a completely different way of doing things. When I travel, people from around the country and, in fact, from around the world ask us about this school. The reasons why are as follows:

First of all, it's who we're bringing in. Last fall, their entering class: 90% of their entrants were from rural and northern Ontario. In that first entering class, there were more aboriginal students than the rest of the Ontario schools combined. They can't make that boast anymore, because after they had that success in the first year, all the other medical schools, if you will, picked up their socks, and we've seen the numbers right across the system—but still, a huge percentage of aboriginal students going in. Some 21% francophone, so equal to or higher than any medical school in Ontario—with the exception of Ottawa, which has a very dedicated program, but still competing with Ottawa. Again, it's a completely different class, and we know from studies from around the world—Australia, the US, Canada, and a number of other countries—that these people are much more likely to stay and work in rural areas.

I'll just point out—because this is inevitably the question that, even if people don't have the courage to ask, runs through the back of their mind: "Yes, so you've got 90% rural and northern and a bunch of aboriginals, but what have you had to compromise on the GPA on their entrance exams?" These students have an equal or higher grade point average, or GPA, than any other medical school in Canada, with the exception of U of T, which is Canada's highest, and higher than anything else. So without any compromise on that very traditional benchmark, there's a fundamentally different type of people going in to look after the needs of Ontario in the future. Again, it's not only a new place and new students, but the mechanisms are also different and how they're doing it is different.

Again, Deputy Minister, just 30 seconds on this: These students are now going out and spending months and months at a time working in very small communities—communities like Atikokan, Dryden, Sioux Lookout, New Liskeard, Temagami and Cobalt. They're working there not for just four days or four weeks out of their four years, but in fact they're there for months and months at a time. They spend entire weeks to months on aboriginal reserves in their first year and going out into francophone communities.

It really is amazing. I went to medical school with a good friend, and then residency. She didn't go to this school; it was before this school opened. But she went

back out onto a First Nation reserve, and now she's writing to me—we exchange holiday and seasonal cards—talking about getting residents from the Northern Ontario School of Medicine onto her reserve. It's a really powerful story about different students in different places learning in different ways, which I think will quickly show some really strong benefits down the road.

Again, some hard numbers and then also a bit of a qualitative sense of how things have changed on the physician side.

Mrs. Maria Van Bommel: I'm really pleased to hear about the increase in the numbers coming from rural and aboriginal. For those of us who live in those communities, it has been an issue in the past, where we may have sent young people into the medical schools and they stayed in the urban areas. We couldn't seem to bring them back, and we had to add extra enticements. It was sort of taking from Peter to pay Paul, robbing from each other to bring doctors into our communities. So I'm really pleased to see the high numbers. That's very good.

Hon. George Smitherman: If our time would allow, I think there are two other things I could ask Dr. Tepper to speak about. You mentioned the older doctors. We're also fighting hard to hang onto those we have—part of an answer that I made yesterday.

The family health team has been a model of practice that really is—just the idea of working in a team seems to have been effective. Also, we've substantially enhanced the compensation levels for family practitioners. It used to be that the way we compensated them was a bit of a push towards being a specialist.

Dr. Tepper, could I call upon you to talk a little bit about the models which have emerged with a view towards retention, keeping in mind some of the older doctors that we are hoping will stick it out for a good long while yet? Also, some of the compensation levels.

Dr. Joshua Tepper: I know my time is short and I'll try to cover it as quickly as possible—"short" being three minutes, so very quickly.

We now have a broad range of compensation models, which I think is really important. As we know, the communities across Ontario and the physicians who work in them are very heterogeneous. It's a very mixed group. So there's a difference between working in downtown Toronto, in Brantford or in Atikokan. We now have things like family health teams, rural and northern group programs, CHCs and family health organizations. People say, "Doesn't that complexity lead to confusion?" Actually, what it lets us do is find the perfect match for each situation. So we now have just under 7,000 doctors—6,971—who are now in some type of model to do that.

The compensation does vary across these different models to some degree, but on average, family physicians are now making—depending on the model and depending on the range of practice that they provide—well in excess, in some cases, of $200,000, $250,000. Some models, if they're really practising in a very broad scope of practice, can be even higher than that.

In the two minutes remaining, just a little bit about the family health teams: Around the world, we're starting to see some questions being asked of us. I see the letters come through to really excellent people in our ministry to help answer. We've got 142 of 150 already up and running and just under 1,000 allied health care professionals already hired—942. That will quickly ramp up. Some 2.5 million patients will probably be served by the end of 2008-09, with 1.78 million already enrolled that we can point and give a name to. So it's a very confident number.

But again, if I could for a second say, it's not just about the numbers; it's about some of the qualitative side. I think what we're seeing in the family health teams, if I can quote Hugh MacLeod, a previous ADM, is "a little bit of magic, of the system leading the system."

I just had a chance to come back from the family health team in Hamilton, back to my alma matter. I went in and had a tour, and it's amazing the teaching that's happening, the way the social workers, the physiotherapists and the nurse practitioners are teaching the medical students, the way all the different learners from across the provider pools are working and studying in a very open-model system. When we start looking at diabetes strategies and chronic disease management, the family health teams are real cauldrons of innovation because they're all there together. We're seeing some really good proposals come forth to really change the way that care has traditionally been provided.

So again, sensitive to time, by the numbers we've seen huge improvements. Some of the softer side—which I think we'll see by the number improvements down the road—is at early days still. It's a bit of a story that's unfolding, if you will. We're seeing a lot of real creativity that comes when you allow and support a wide range of family care providers to work together, focused on a patient-centred model, which is what the family health teams are. It's about putting the patient, the client, the family, right in the middle and letting everybody who's around them bring their respective skill sets to bear. Mr. Chair, hopefully within time.

1740

The Chair (Mr. Tim Hudak): Do you have a last quick question, Mrs. Van Bommel?

Mrs. Maria Van Bommel: I wanted to address another issue, but there won't be enough adequate time. Your excitement is very catching.

Dr. Joshua Tepper: It is very cool.

Mrs. Maria Van Bommel: It is very catching. Thank you very much.

Mr. Lou Rinaldi: I shouldn't have given up the time, Chair.

The Chair (Mr. Tim Hudak): All right. The last 20 minutes of our session today are the official opposition's. Mrs. Witmer.

Mrs. Elizabeth Witmer: I'd like to come back to long-term care. We were on the issue of the promised 35,000 B and C rebuilt homes. My question is quite simple: Will the homes in the areas where there are

currently shortages of long-term-care beds be able to apply for additional beds as part of this program?

Hon. George Smitherman: No, with one caveat. The aging-at-home resources, which I've spoken about a few times, are in the hands of local health integration networks, and they could choose—keeping in mind that I've already mentioned that they will be involved in helping to prioritize the B and C redevelopment. If the local health integration network concluded that—I'm just making up a number—20 additional beds would create critical mass for a home, then the LHIN does have flexibility to make allocations from their aging-at-home allocation.

Last week in Timmins, the local health integration network indicated that they will use some of their resources to build, I think, 64 long-awaited long-term-care beds. So there is that flexibility from the aging-at-home budget line that is in the hands of local health integration networks.

Mrs. Elizabeth Witmer: That's right. But not from the rebuilt 35,000—

Hon. George Smitherman: That's right.

Mrs. Elizabeth Witmer: Okay. That's great.

You announced last year, in 2007, these 1,200 RPNs, and that was to start this January. Of course, the homes have received their funding for January to March. I'd like to know when the homes are going to get all of the information and the details on when the money's going to flow and how they can spend it.

Hon. George Smitherman: I think that information comes through in July, apparently. I don't know if it's—

Mrs. Elizabeth Witmer: Right now they only know what they received between January and March. We're now into June. So they don't know how much they're going to get for the rest of the year and they don't have any details for future years on how they can spend the money.

Hon. George Smitherman: I find this unsatisfactory, but I'll find out what communication has been provided. I have no idea why it would make any sense at all to communicate to March and to have created a disruption in that flow. So we'll seek to get to the bottom of it. My note says July, but I don't know the source on this, and I don't find that a very acceptable answer. So let's see whether the LHINs have been more effective at communicating those allocations.

Mrs. Elizabeth Witmer: Because obviously the homes need to plan—

Hon. George Smitherman: Obviously.

Mrs. Elizabeth Witmer: —and the staff need to have some job security.

Hon. George Smitherman: Exactly.

Mrs. Elizabeth Witmer: Secondly, they need staff. We all know that. The budget promised 2,500 additional PSWs over the next three years and those 2,000 nurses over the four. When are the homes going to receive any of that promised money in the budget to hire these staff?

Hon. George Smitherman: I think you may have been out of the room, because this was a matter that I—

Mrs. Elizabeth Witmer: I know she did, yes, but I'd just like to hear—

Hon. George Smitherman: Firstly, just to remind the honourable member that a review of her party's platform for the election didn't call for any additional staffing in long-term care. It only talked about food allowances and the capital renewal.

Eight hundred and sixty five of those personal support worker positions for implementation August 1 of this year; information to flow to long-term-care homes; no determination yet made about how many of the 2,000 additional nursing positions—which are above and beyond the 1,200 RPNs that we've been speaking about—no decision yet on implementation on those, but that's a matter that we're working on closely at the moment; and, overall, engaging in conversation with the OLTCA and OANHSS to enhance our capacity to communicate. You've highlighted that some of it has been a little bit inconsistent and so we're working with them also to create a good mechanism, when we are in a position to put additional resources into the system, so that we've made sure that those resources are being dedicated to the most appropriate settings.

Mrs. Elizabeth Witmer: These PSWs were for over the next three years. Are people going to get any advance warning as to how many PSWs each home is going to get and when they're going to get that funding over that three-year period?

Hon. George Smitherman: As the—

Mrs. Elizabeth Witmer: The first tranche, you said, is going to happen August 1. But, I guess it comes to long-term planning and being able to hire the appropriate staff.

Hon. George Smitherman: Yes. That's why a couple of times I have referred to the necessity of our conversation with the two associations, and that work is ongoing. We're trying to create a good plan that will provide people with the information that they need in a timely way, but as I sit here, I couldn't give you the assurance that all of those i's are dotted and the t's are properly crossed. We have some work to do on this yet.

Part of the discussion relates to the fact that, across the breadth of long-term-care homes—628, I think, is the current count of long-term-care homes in Ontario—we're also trying to be mindful of what is the starting point that's there and to make sure that, as we make allocations of additional resources, we're getting them to the places where they are going to be most beneficial, trying to make sure that the allocation model isn't rewarding a poor investment strategy. We're trying to balance all these things out, and that's why a conversation with those two associations is essential to be able to do this work well. That's work that's ongoing. It's also work that will be informed by the initiative that I mentioned a few moments ago, which is our hope that Shirlee Sharkey will be able to lead a process that gives advice around these implementations, a process that would be multi-stakeholder and involve all of those parties interested in long-term care: the representatives of workers, the rep-

resentatives of residents and family councils, the representatives of the associations, and relevant individuals from the ministry. We're trying to create a multi-stakeholder approach to the implementation of these investments, trying to get everybody on the same page.

Mrs. Elizabeth Witmer: I understand. I would just say that some of these announcements go back to 2007. We have residents who desperately need more personal care, and it is important to make sure that the announcements, the actual commitment and the bodies are in place.

My question is: How many nurses will each home receive in the next four years and when will they begin to receive that funding? We've just talked about PSWs. I'm talking now about the nurses.

Hon. George Smitherman: I'm not in a position to be able to answer that specifically yet.

Mrs. Elizabeth Witmer: So we don't have that. Okay.

Hon. George Smitherman: But I could just remind the honourable member—she said that the resources are "desperately" required—that her party's recent platform didn't call for any additional investment in staffing.

Mrs. Elizabeth Witmer: We'll now turn to the additional 2,000 nurses for long-term care. There is a nursing shortage in Ontario—in fact, across Canada. We know that small homes in rural areas have a lot of difficulty trying to recruit and retain nurses, for which they're already funded. Since we're talking about enhancing resident care, I'd like to ask you, Minister: Are you prepared to let the homes recruit both RNs and RPNs with this money that was designated for 2,000 nurses?

Hon. George Smitherman: The allocation of those 2,000 nurses will include an amount of—well, no final decision has been taken around that, but I believe that the bias would be towards those being registered practical nursing positions.

Mrs. Elizabeth Witmer: Okay. Let's go further. There is this really desperate need in some places to find nurses, and they can't find them. If they can't find them, would you be prepared to allow them to use this funding to fund other staff, or are you going to force them to give back the money to the government?

Hon. George Smitherman: I think that the data out there about the percentage of registered practical nurses who enjoy full-time employment demonstrate that the capacity to find registered practical nurses in the province should be quite good for long-term-care-homes. I have heard from some long-term-care home operators who would prefer to have, instead of nurses, something else. But no, it would be our expectation that we would be implementing 2,000 additional nurses in the long-term-care-home environment. The expectation should be created from here that those would be registered practical nursing positions.

Mrs. Elizabeth Witmer: We do hear from the homes in rural and remote areas about the difficulties that they have in hiring nurses, whether it's registered nurses or registered practical nurses. I was asked if I would raise this particular issue. If they can't find someone—and it is a real problem—would they be required to give you back the money, or would they be able to hire PSWs?

I bring that to your attention. You've answered. I just want to raise it as a concern.

1750

Hon. George Smitherman: I have heard the issue much more in the context of the difficulty of finding an RN. As we had a chance to mention before, on the 24/7 RN provision, we have, especially with those small homes and those in rural Ontario, sought to be very, very flexible, so I'm mindful of the challenge, but I don't think it's equal to say that it's as difficult, necessarily, to find an RPN as it is to find an RN. It's likely, as I've said, that the 2,000 nursing positions would be registered practical nurses. If you look at those who are graduating and if you look at the percentage of registered practical nurses working full-time, I feel very confident about the ability of the long-term-care-home sector to provide very good stable employment opportunities for those RPNs. Of course, that's something that we're always going to measure, but we do think it's important to add these nursing positions to the complement of staff, alongside the other PSWs which we've spoken about.

Mrs. Elizabeth Witmer: Okay. Further questions about the budget this year: It announced $107 million over three years for 2,500 personal support workers—we've talked about that—and $110 million over four years to hire 2,000 nurses. This is in addition to the annualization of last year's $14-million announcement of 1,200 RPNs. My question is: What are the estimated amounts for these three categories for this fiscal year and next year, 2008-09?

Hon. George Smitherman: I can't unravel that question off the top of my mind, but certainly what we could prepare for you is—I guess I could use the word "profiling"; as I've had a chance to mention on the PSWs, for this year, 865 for implementation on August 1. We'll do our very best within the numbers that are there to show you how the budget lines up with the profiling and allocation of those positions. So we'll definitely get back to you with some additional information on that.

Mrs. Elizabeth Witmer: Will your funding approach be similar to what you rolled out in February with regards to the RPN hires?

Hon. George Smitherman: I think we can do a lot better, and my expectations are that we will. Part of that is the conversation that I've mentioned two or three times on the necessity of working this out with the associations. I think that we have to improve our capacities. As I mentioned a couple of times as well, we really hope that we can create this capacity, with all the players in long-term care working together. It's certainly our hope that Shirlee Sharkey will be able to lead us forward in a way that also gives us some insights into how to better implement additional staff allocations in long-term care. Our hearts are in the right place etc., but I do think that there are ways to improve on the implementation, and

we'll be looking for all parties to assist us in advice around that.

Mrs. Elizabeth Witmer: Will the funding only be provided if homes are able to hire new full-time equivalents?

Hon. George Smitherman: I don't want to get caught up on the full-time equivalent piece at present, because it may be that an allocation of RPN hours to a home might allow them to transition two or three RPNs to full-time employment. This is an area where we will talk about our commitment to the people of Ontario for X thousand of additional nurses, but seek to be as flexible as we possibly can, because local circumstances may dictate that the best allocation of the equivalent of a full-time position is those X thousand additional hours split among two or three existing staff to bring all of them up to full-time employment—we think that we should be flexible on that point, measuring the hours to ensure that all the dollars that go in buy the additional hours that a full-time equivalent would create.

Mrs. Elizabeth Witmer: In some respects you've responded to the next question I wanted to ask, and that is: Since you're not providing the full cost of the RN, the RPN or the PSW, would homes be allowed to convert part-time positions to full-time?

Hon. George Smitherman: I didn't understand the premise of your question. Of course, we'd be looking to provide the cost of a full-time equivalent on an annualized basis.

Mrs. Elizabeth Witmer: So you will be providing the full costs of all of these positions.

Hon. George Smitherman: Yes.

Mrs. Elizabeth Witmer: How do you expect that they can maintain the staff that they have and hire new staff if there's not a significant increase in NPC or PSS to maintain the staff they currently have? This is an issue that we're being asked about.

Hon. George Smitherman: I don't even know what those—National Public Radio, NPR?—refer to exactly, but I think that there's a slight bit of confusion here, which may have been corrected by now. The funding envelope for long-term care had two different kinds of what I would call—because the measure of resource for long-term care depends on this acuity, this mix, it's a little different than saying "base budget increases." There are two different increases for long-term care, and they come forward as two different communications that total more than 3%—I think almost 3.5%—as a kind of base budget equivalent. This is a satisfactory amount to be able to pay for the increases in the cost of living for existing staff, which allows those new investments to pay for new hours of care.

I think that the long-term-care sector has greater information about the increases for this year, some of which are flowing out directly from the ministry and some of which are flowing out from LHINs, so I'm very confident that the amount of base increase for long-term care will allow them to pay for the cost of living for keeping their existing staff in place and will allow the additional investments to purchase additional staff.

Mrs. Elizabeth Witmer: So you're guaranteeing that they have enough money to pay for their current staff and hire new staff.

Hon. George Smitherman: Yes. Well, I think the word "guarantee" is a bit of a loaded one. You and I both know that in rare circumstances a long-term-care home will transition to a much healthier lower-acuity group of patients, and appropriately, we would say, the measure of the number of employees will be altered as a result of that. So there are changes that occur in homes, but the increase that the government of Ontario is providing to the base circumstances of long-term-care homes is certainly sufficient for them to be able to increase the compensation associated with the cost of living for their current employees, yes.

Mrs. Elizabeth Witmer: And hire new ones.

Hon. George Smitherman: And then the new funding, which we've spoken about at length, would be dedicated to the purchase of new hours. Just to be clear: If we're sending money into a home that's got the equivalent of X hundred or X thousand hours, we will, through the work that we do in surveying the data of hours, expect to see the additional hours provided to the residents, no doubt.

Mrs. Elizabeth Witmer: I just want to get into the whole issue of incontinence, which has been raised course, and did generate some strong public concern. Does the budget contain any additional funding to address that whole issue of incontinence products?

Hon. George Smitherman: The issue of incontinence products—an issue that I know rather too much about. I should just defer to the deputy.

Mrs. Elizabeth Witmer: Is there money in there for additional funding?

Hon. George Smitherman: The Ministry of Health did implement additional funding because there was a determination that has been made broadly that a higher-quality incontinence product was warranted, and that has been implemented broadly across health care. What we seek to do in addition to that is to enhance by thousands the number of people who are working in long-term care to help address the underlying challenges for incontinent residents.

Mrs. Elizabeth Witmer: Let's take a look—I know there's not much time left—

The Chair (Mr. Tim Hudak): Less than two minutes.

Mrs. Elizabeth Witmer: Human resource costs: Are you going to flow through the RN signing bonuses into 2008-09? If so, how much is allocated in the estimates this year for that purpose?

Hon. George Smitherman: It was a one-time allocation, a 2007-08 Ministry of Health allocation, so there's no flow-through required. It was one-time, and it was allocated to nurses and related to the Ontario Nurses' Association agreement with the Ontario Hospital Association that paid out bonuses based on a formula suggested by those parties and which rewarded long

service—was weighted, if you will, towards the length of service of the employee. That was a one-time initiative already funded in 2007-08.

The Chair (Mr. Tim Hudak): That does conclude our time. Thank you, Mrs. Witmer. Thank you, Minister, Deputy Minister and folks from the Ministry of Health.

That will end our hearing today. Just a reminder: We reconvene Tuesday, June 17 at 9 a.m. until 10:45, reconvene from 4 until 6, and then we have just over an hour of additional time on Wednesday the 18th, which we will meet for unless there is an agreement among the three parties to stand down time on Tuesday. Otherwise, we'll meet Wednesday the 18th. If we do recess for the summer, we resume this hearing in the fall, in September.

Minister and Deputy, thank you very much. Folks of the committee, thank you. This committee is now adjourned.

The committee adjourned at 1801.

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