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Tuesday 27 September 2005

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Mardi 27 septembre 2005

Standing committee on estimates

Ministry of Public Infrastructure Renewal

Ministry of Health and Long-Term Care

Comité permanent des budgets des dépenses

Ministère du Renouvellement de l'infrastructure publique

Ministère de la Santé et des Soins de longue durée

Chair: Cameron Jackson
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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON ESTIMATES

COMITÉ PERMANENT DES BUDGETS DES DÉPENSES

Tuesday 27 September 2005

Mardi 27 septembre 2005

The committee met at 0906 in room 151.

MINISTRY OF PUBLIC INFRASTRUCTURE AND RENEWAL

The Vice-Chair (Mr. John O'Toole): Good morning. The standing committee on estimates reconvenes. The first order of business is to find a temporary—

Interjection.

The Vice-Chair: We're OK now? Very good. The clerk has advised me that we'll start this 59 minutes, which will be divided among the three parties. Seeing as there's no one from the official opposition here except me, we will skip that rotation. Oh, Jim Wilson has just appeared. That's great. With that, if it's the wish of the committee, we could let Mr. Hampton start first on this round. Each party will have 20 minutes. Mr. Hampton, you have the floor.

Hon. David Caplan (Minister of Public Infrastructure Renewal, Deputy Government House Leader): Excuse me. Do I not have time for closing comments?

The Vice-Chair: The way that will work is that it will be divided among the three parties, and you'll finish the session, technically. We'll go to Mr. Hampton, then we'll go to Mr. Wilson, then we'll go to you and the government side.

Hon. Mr. Caplan: So the government side doesn't get another balance of questions? OK. I was just looking for clarification.

The Vice-Chair: If you want, it's from your time.

With that, Mr. Hampton, your time starts now. You have 20 minutes.

Mr. Howard Hampton (Kenora–Rainy River): I have some more questions. Minister, yesterday you told us that the major risk that the government was interested in dealing with in these private financing deals is that you wanted to privatize the risk of delays and cost overruns. Is that right?

Hon. Mr. Caplan: I indicated, Mr. Hampton, that there were several risks, as have been outlined in the Building a Better Tomorrow framework. Mr. Chair, I have included copies of Building a Better Tomorrow for all of the committee members. Pages 30 through 33 outline the risks that we do identify—some of which of course would be transferred; others would not be transferred—and the kind of analysis we would go through on a case-by-case basis. The top risks for the government would be delivery risk and financing risk. Those are ones that we are especially concerned about, but I don't want to minimize any of the others we outline, and the process we would go through in order to assess them.

Mr. Hampton: So just to repeat, the major risks—I asked you this question directly yesterday, and you said the risks you wanted to deal with were cost overruns, which you've classified as financial risk, delay risk, and then the third one you talked about was building maintenance, or what you referred to, I think, as life cycle risk.

Hon. Mr. Caplan: Life cycle, and there are other risks as well, as I have indicated, that we are also paying due regard to.

Mr. Hampton: I think you also pointed to what you called international evidence. You said that this international evidence was very supportive of private financing deals. Is that right? I think you actually referred to the British Auditor General.

Hon. Mr. Caplan: I did refer to the report of the UK Auditor General. That's correct.

Mr. Hampton: Yes. What sticks out like a sore thumb in Britain—you keep saying that these private financing deals in Britain are something like 80% on time and on budget. I think was the figure you used. Is that right?

Hon. Mr. Caplan: I indicated that the study of the UK Auditor General indicated that 88% of the time, the projects they studied were delivered on time and on budget, and that compared to what would be considered the more traditional public works model, as studied by the UK auditor, 70% of the time projects were delivered over budget and not on time.

Mr. Hampton: So you're quite impressed with that 88% figure.

Hon. Mr. Caplan: I just report what the UK Auditor General indicated.

Mr. Hampton: OK. I want to bring to your attention some other things in the UK, and you can tell me if these are acceptable. With the Carlisle infirmary P3, Carlisle hospital, one of your private financing projects, this is what they found. Design problems and shoddy construction have plagued the hospital as follows: Two ceilings have collapsed because of cheap plastic joints and piping and other plumbing faults. One joint narrowly missed patients in the maternity unit. The sewage system could not cope with the number of users and flooded the operating theatre. Clerical and laundry staff cannot work

in their offices because they are too small. Expensive trolleys had to be commissioned because those supplied don't fit between the beds. The transparent roof means that on sunny days, the temperature reaches over 33 degrees Celsius. The hospital has no air conditioning. Two windows have blown out of their frames, one showering a consultant—that's what you call a specialist physician in Britain—and a nurse with glass. One of the risks supposedly transferred to the private consortium was the risk that targets for clinical cost savings would not be met, and the cost of this risk was estimated at £5 million. The consortium, however, faced no penalty if these savings were not made. Therefore, £5 million of value was spuriously attributed to the private financing model.

What I found yesterday was that when I asked you to evaluate any of the risks, to put a number to them or to give us even ranges, neither you nor any of your officials seemed to have a clue. I want to ask you, would you consider the outcome of the Carlisle infirmary P3, if it came in on time and on budget, a successful undertaking?

Hon. Mr. Caplan: Well, I think that we want to learn the lessons from all of the examples that exist, both domestically and internationally, whether they are traditional public works models or whether they're alternatively financed types of projects. We have international evidence from 600 PFI projects in the UK, from projects in Sweden, often cited by yourself and others as an example of the way to finance and manage many of the public services that people rely on. We have examples from Ireland, from Australia, from British Columbia, from Alberta, from Quebec, from the United States—thousands of projects successfully delivered. Examples where there are some lessons and some experiences do not negate the instances where they have been successful. I would suggest to you that one of the purposes of coming up with a framework was to build upon many of those examples and to ensure that we learn the lessons and do not repeat ones that perhaps did not have successful outcomes but also to emulate practices that did.

Mr. Hampton: It was you, not I, who was telling people how wonderful private financing was in Britain.

I want to raise another instance with you: the Dartford and Gravesham, otherwise known as the Darent Valley Hospital in Kent. Innisfree, which is the financing agent, refinanced the hospital and made £33 million in profit. One of the companies, Carillion, the same company that has won the bid on the Brampton hospital under your government, made £11 million in profit. The hospital, however, failed inspections for basic standards in hygiene, trolley waits, cancelled operations and breast cancer referrals.The CEO was fired. Community health spending has been reduced to fund the additional costs in the hospital. Funding for the provision of services shifted to the community—mental health and learning difficulties, and community nursing—was withdrawn. In order to increase funding for the private financing hospital by 2 million pounds per year, funding for a child resource centre, relocation physical disability services, and relocation mental health services were cut entirely. Community nursing and community hospital services were reduced.

You say once again that your primary concern is on time, on budget. Does this hospital sound like an acceptable result to you?

Hon. Mr. Caplan: Mr. Chair, I'm certainly guided by the words of former Attorney General Howard Hampton, who said, "As well, Metro Toronto presents, in the longer term, some interesting possibilities for partnership with private developers. For example, it might be possible to construct courts and to construct commercial space and to construct housing in co-operation with a private developer."

In fact, Mr. Hampton, it was your government—you served on the executive council—which introduced P3 concepts into Ontario. I wish to quote your colleague at the time, Mr. Farnan, the Minister of Transportation: "This international model is used everywhere—in Germany, the United States of America and many other parts of the world. By allowing partnerships with the private sector and changing the way we build highways, we are positioning our industries to be the world leaders and at the same time we are getting the job done faster and we are saving the taxpayers a lot of money."

Mr. Farnan continues, "Using our method of constructing Highway 407"—the first P3 in the province of Ontario, under your government—"we will create 20,000 jobs now, when they are most needed, save the taxpayers $300 million, encourage private sector partnerships and encourage innovation and competition. We will build a much-needed highway 22 years faster. Lastly, but most importantly," said Mr. Farnan, "we will help Ontario's design and construction industry catch up with the rest of the world to build large-scale products like Highway 407 in an innovative and effective manner."

I say to you, Mr. Hampton, that this was the position, the testimony. In fact, you, as a member of the executive council of Ontario, approved and passed the capital investment plan in 1993 in order to encourage this kind of arrangement, a partnership between the public and private sectors. We have, I submit to you, learned some of the lessons of your government's move in this regard, and of the previous government's initiative as well, and we have come up with an alternative model called alternative financing and procurement. It is different from your P3 program and different from the Tory P3 program. It is rooted in five fundamental principles outlined in this document. I have talked to this committee about it, and I will elaborate on it again.

Public interest is paramount, that we have appropriate public control and ownership—

Mr. Hampton: Chair, is this in answer to the question? I asked him about a particular hospital in Britain.

Hon. Mr. Caplan: It was a very particular question, and I'm providing you with an answer—that we have demonstrated value for money, that there be proper accountability lines, and of course—

The Vice-Chair: Mr. Hampton, are you satisfied with the answer to this point?

Mr. Hampton: I asked about a particular hospital in Britain, and I—

The Vice-Chair: Are you satisfied with the answer?

Mr. Hampton: I'm satisfied with the answer.

Minister, it's a shame that you don't know the difference between renting temporary court space in an available building and the private financing and operation of a hospital, or that you don't understand that the 407 was not private financing. Private financing was rejected because the government of the day realized that private financing would cost the taxpayers of the province tens of millions of dollars more. It's a shame that you, as minister, don't know these elementary facts.

0920

But I want to ask you about another hospital. As you say, the McGuinty government's concern is that you want the construction on time and on budget. I want to ask you about the Royal Infirmary of Edinburgh, a private financing hospital in Scotland:

The hospital was built without operating theatre lights. The hospital lands in town were sold off in a scandal-ridden land deal and the hospital was moved to a greenspace outside of town. The land that the hospital is located on is over an old mine and rats climb to the surface and infest the hospital when it rains. The high costs of the private financing have been borne by reducing beds in a false estimation of faster patient "throughput."

Beds have been reduced by 24% across the health district and community services have also been cut. Further reductions in community care and beds may be necessary to meet the financial deficit, primarily due to the high costs of private financing in the health district. The workforce plans for the new private financing hospital show that the projected clinical staff budget was 17% less than in the former public hospital. The new private financing hospital was planned to have 18% less staff.

Capital costs as a proportion of total income rose from 7% to 14% under private financing. The head of the accident and emergency department, Keith Little, resigned in 1999 on the grounds that the shortage of beds had made his job impossible. One of the ways that figures have been adjusted to indicate that private financing provides greater value for money was the assumption that the building life would be 45 years rather than the usual 60 years.

Does this sound like a successful outcome to you? I'm told that it came in on time, on budget. Does this sound like a successful outcome to you?

Hon. Mr. Caplan: Well, Mr. Hampton, I must say that the government between 1990 and 1995—in fact, I'll quote from Public Investment for Economic Renewal, February 1993: "Growing and changing demand for infrastructure, increasing pressure on existing infrastructure systems, and difficult financial constraints have reduced the effectiveness of traditional methods of planning, financing and managing public infrastructure." I want to remind you, sir, that you were a member of the executive council and the Attorney General of the day when these statements and this methodology were first introduced in Ontario. I want to go on: "New approaches are needed.... [These new approaches] will need to accommodate a shift to a loan-based financing system consistent with the long-term nature of capital investment, facilitate new financing arrangements with public sector partners, and open up new sources of financing."

Mr. Hampton, I want to be very clear that our methodology is quite a bit different than the P3 approach of your government and quite different than the P3 approach of the Conservative government. I believe that I have demonstrated already that we have identified it and rooted our move forward, whether it's simply private sector finance, whether it's a combination of federal, provincial and municipal cost shares, whether it's developing a low-cost loan pool like OSIFA, whether it's developing another alternative financing means like providing a revenue stream to municipalities like the gasoline tax. We are taking a multi-faceted approach toward delivering the infrastructure, finding new ways of investment; in fact, we are using debt finance and other kinds of means.

Mr. Hampton: Chair, I think my question was about a particular hospital in Scotland. I haven't even heard reference to the word "hospital" yet in the answer.

Hon. Mr. Caplan: We are learning lessons, both domestically and internationally, whether it comes to roadways, hospitals or courthouses, whether it is on municipal finance or areas in the province.

The Vice-Chair: Mr. Hampton, are you satisfied with the answer? This is your time, and the minister is trying to give you an answer. Are you satisfied with the answer?

Mr. Hampton: It's not a very good answer, but I am satisfied nonetheless.

Minister, one thing you didn't note in your answer is that the reference to loan financing was exactly the thing that was rejected in Highway 407. It actually came to a cabinet meeting, and private financing was rejected, and the reason it was rejected was because private financing of that kind of capital project would cost the taxpayers of the province tens, if not hundreds, of millions of dollars more. It's really a shame that I have to remind you of history that's fairly elementary, that your staff obviously hasn't briefed you, as minister, very well, or you didn't understand the briefing.

But I want to ask you about another hospital—as you say, these projects have all come out on time and on budget. This is the East London and The City Mental Health Trust, in East London:

"A leaked report from consultants Hornagold and Hills noted the following problems: The bidding and the negotiating went on for two years beyond deadline, even after which the contract did not adequately specify the obligations of the private companies; the architects were not paid, did not inspect works or certify completion and there are no drawings of the final buildings; the original design provided no office space at all, a redesign to squeeze in offices is extremely poor; gender segregation in the wards is impossible due to design flaws; the water

supply totally failed upon the building opening; a number of toilets were not connected to drains, leading to ‘obvious problems’; floor coverings are defective; alarm and call systems unreliable; emergency systems non-functional; staff were ill-informed and alienated; and the contractor was deemed uncooperative and adversarial.”

According to you, as long as these projects come in on time and on budget, they’re acceptable. I ask you again, is this an acceptable outcome for a hospital?

The Vice-Chair: There’s one minute left.

Hon. Mr. Caplan: The question went quite long, and I’ll endeavour to stay on time.

I want to note that even more recently than the period between 1990 and 1995, in 1997, the deputy leader of your party, Ms. Churley, said on February 5 in Hansard:

“OCWA”—the Ontario Clean Water Agency—“was created under our government and it is an example of the benefits of the partnership between the public sector and the private sector.”

Mr. Hampton, your assertion that certain things happened in history is, I believe, fundamentally incorrect.

“I have no problem with these kinds of partnerships,” Ms. Churley went on. “I think they make sense. There are a lot of ways that the government can work together with the private sector to enhance the services we provide, to make them less expensive. There’s a way that everyone can win in these kinds of public-private partnerships.”

Mr. Hampton, I think the point here is that when faced with the fact that there was a need to deliver capital and infrastructure projects in a different way, a need to improve the financing of the them, your government turned to and looked at some of these innovative methods of public financing, innovative methods of project management and delivery.

I want to assure you that we are not being indiscriminate the way that your government was, but have rooted how we are moving forward with a variety of strategies in some core and fundamental principles, which were, I would add, widely consulted on, unlike the approach that your government took. I think we’ve learned many of the lessons, both at home and abroad, as far as how we move forward in these kinds of matters.

I know that Ontarians wait with great anticipation for the construction of new infrastructure that will enhance and provide state-of-the-art, modern medical services and lower class sizes, which will provide the foundation for a prosperous economy, and that is precisely what we’re going to do.

The Vice-Chair: Thank you very much, Minister, for that. We turn to the opposition side for the next 20 minutes.

Mr. Jim Wilson (Simcoe–Grey): Thank you, Mr. Chairman, and thank you, Minister, for being here. I wasn’t here yesterday, so you may have covered some of the questions I may ask you. I was expecting to show up and see Mr. Smitherman in your place this morning, but I guess we still have an hour of your ministry, which is great.

The first thing I want to do is to read a letter to you. It’s very brief. It’s from Audrey Johnstone, who’s the clerk of the town of Wasaga Beach. It’s dated September 12, 2005, and it’s just about OSTAR funding and some billing problems they’re having, which you have straightened out in the past for us. I’ll just read this:

“Dear Mr. Wilson,

“We are facing difficulties as it relates to payments for claims submitted under the OSTAR program and are once again requesting your assistance. We are continuing with the infrastructure project through the OSTAR program for the installation of water mains and sanitary sewers and the project is proceeding as planned; however, as noted, we are once again having difficulty with payment claims. We have payment claims dating back to April 1, 2004.”

There are a couple of short paragraphs left.

“To date we have submitted claims totalling $4,339,727.33, of which 66% are claims the town is looking for to come back through the OSTAR program.

“We had great success”—this is the best part—“with your ... assistance” last year, “so may we ask that you once again look into this matter.

“We extend our sincere appreciation.”

0930

Hon. Mr. Caplan: Can I comment?

Mr. Wilson: Please.

Hon. Mr. Caplan: You did approach me last year regarding a similar matter. I’d be very happy to follow up with you if you would have either yourself or your staff provide me with the letter. It is through a sister ministry, but we’d be more than happy to follow up with you on behalf of your municipality.

Mr. Wilson: Thank you. I’ll give you a copy of this letter. Last year, I must admit, within about two days, you had the whole problem solved, and it was the town of Wasaga Beach also. For some reason we have an invoice problem there.

I was going to ask Mr. Smitherman, but I’ll take the opportunity to ask you: The Markdale Hospital, which they call the Grey Bruce Health Services, is the only hospital between Owen Sound and Orangeville that has a 24-hour emergency department. It’s located on Highway 10, which I’m told is the busiest provincial highway in the province. I’m not sure that’s true, but it must be in the top 10. When they approached the Ministry of Health to build a new hospital, I guess originally in 2002—this hospital is quite old and quite falling apart. We have a severe shortage of physicians in the area and we’re hoping that a new hospital will help to attract new physicians to the area. When they approached the ministry in 2002, the ministry thought it would be impossible for a community of about 6,000 people to raise their share of the money, which was about a $12-million target. Two Saturdays ago, they had a ceremony in which they raised $13,131,355. Dr Hamilton Hall headed that effort on behalf of the community.

I guess I’m just asking, as Dr. Hall asked me yesterday on the telephone, where do we go from here? They’ve got what we would call draft sketches of their concept. Their concept is a new concept in terms of integrating the

Grey Gables site, which is the long-term-care facility in Markdale that our government built. They want to put a hospital on that site. They want to integrate acute care, primary care and long-term care all on one site—shared kitchen facilities—do everything efficiently and actually be a real model for rural health care. They'd like to go to functional plans. Do I ask Mr. Smitherman for that permission? When I talk to Ron Sapsford and his assistant deputy minister and the minister himself, they often refer us to your ministry because you are the guru of capital. What's your advice in terms of where this hospital goes? As I said, three years ago Queen's Park told them, "You'll never raise $12 million." Indeed, they raised over $13 million. They're ready to go, to put a spade in the ground. Where do they go from here?

Hon. Mr. Caplan: First of all, I want to thank you, Mr. Wilson. I've never been described as a guru of anything, so I think that's rather kind of you.

We work very closely, obviously, with the Ministry of Health when it comes to health care capital, or the Ministry of Transportation when it comes to transit, roads and borders, or the Ministries of the Attorney General and Community Safety and Correctional Services regarding justice capital. I describe public infrastructure renewal somewhat facetiously as something of a leasing office on steroids. Once the policy decisions are made by the individual ministries as to what public service they wish to deliver, what their transformation strategy is, what they're going to deliver in a geographic, regional or local sense, they'll come to us for a financing solution. They'll come to us for help with project management, delivery, contract negotiation and all the like. We do provide funding to ministries like the Ministry of Health to assist municipalities with planning grants.

I don't know the exact figure off the top of my head, but in a very general sense, in 2005-06, in this budget year, we will be investing almost $340 million in health capital. Over the course of the next five years, our level of capital investment in health care will be some $5 billion. We have planned out 105 health care projects, which will be either completed or started over the course of the next five years. We have talked to hospital boards and local members; we have begun the announcements and begun to signal the start dates. I can't share any of the individual details, but I can tell you about the process that we went through and the framework for decisions. On the health side, the health ministry took a look at the factors of transformation, the wait time strategies in the specific areas of cataract, cardio—and you well know, I'm sure, the Minister of Health will be glad to elaborate on that. We took a look at growth needs. We have some explosive growth in certain sectors of the province and we don't have adequate health care facilities or the ability to access, so we wanted to make sure we are meeting some of the growth needs. We also have renewal pressures: very aged buildings that are in a state of disrepair that we either wish to add to or fix up substantially. So those were the major factors.

As well as aged buildings and project readiness, there was another filter, which is that we wanted to achieve a measure of regional equity around the province. We would not do everything in eastern Ontario to the exclusion of northern or southwestern Ontario. The other two factors were placed by my ministry. One was the dollars available and the cash flows that we would have to be able to support those 105 hospitals. The last one, of course, is a measurement of the relative construction capacity in Ontario. The way I described it yesterday to this committee is that, in reality, there are only about five major construction companies with the bonding capacity and the capacity to do the actual builds. We simply cannot exceed our ability to deliver health care capital. So, in a five-year time frame, we have ordered, staggered and phased what we believe we can handle with the current construction capacity in Ontario.

I want to add one last point. I'm just trying to be as tight as I possibly can.

Mr. Wilson: Yes. I used to be a minister; my answers were actually twice as long.

Hon. Mr. Caplan: I just want to add one more point. If—and our hope is that—by signalling on a longer term basis what our capital vision is and what our financing plan is, we can build additional construction capacity; and if we can get additional revenues—I know they are two rather large ifs, and I was heartened by Minister Sorbara's comments in the spring budget that, with any realization of asset sales or unanticipated revenues, infrastructure would be the first call for reinvestment—we would like to expand our lists and our projects that we'll be supporting. So if we can get more construction capacity, if we can get more financing—I guess the short answer to the Markdale hospital is, come and talk to us and come and talk to health.

Mr. Wilson: I've heard about this list of over 100 hospitals that I guess you're rolling out approvals for at various stages of construction or planning. Unfortunately, in opposition it's very difficult to figure out whether you're on the list or not. Minister Smitherman has been very kind to the local people every time they've talked to him, but they are having a very deep sense of frustration over whether they're on the list or not.

So are you going to release the list of 105 health care projects that you're prepared to fund over the next few years, or am I wasting a lot of taxpayers' money and time by coming here and beating my head against the wall on behalf of the community?

Hon. Mr. Caplan: It's never a waste of time coming here and having accountability and oversight on government spending. I think this is a very worthwhile and useful endeavour for this legislative committee.

Our intention is to work with local communities, with local hospital boards, and have our conversations with them about what will be proceeding and the schedule of things that will be proceeding; also, the finance methodology that we intend to use as far as moving individual projects forward. That is the method that we are going to be using, given the policy filters, given the regional equities, given the cash flow and the construction capacity elements that I described in my earlier conversation.

I do want to indicate that if we are able to do more faster, we certainly are very interested in doing so, but we believe we have taken a very responsible and realistic approach to providing for the kind of pent-up demand for health care capital.

0940

I'm often quoting a very illuminating figure, that the average age of a hospital in the province of Ontario is 43 years old. How dedicated our doctors and nurses and other medical professionals are in providing exemplary care to Ontarians is impaired by not having access to state-of-the-art health care facilities. That's why we are embarking upon, I believe, the largest health care capital expansion in this period of time and why we feel such a sense of urgency to bring innovative and alternative kinds of methodologies to be able to do the task.

Mr. Wilson: You'll be hitting a record if you actually fund and get started on these projects, Minister. You've made a lot of announcements, but we've seen very few spades in the ground, as you know.

Hon. Mr. Caplan: Yesterday, your colleague Mr. O'Toole talked about the Peterborough Regional Health Centre. We have started construction there. We had groundbreaking in Listowel just a couple of weeks ago. I know that has begun as well in your colleague Mr. Sterling's riding, in Almonte; at least I believe so. And there are many others.

Mr. Wilson: So when you want to drive up Highway 10, don't forget to stop in at Markdale and take a spade. I'll be happy to supply it.

Hon. Mr. Caplan: After I deal with Wasaga Beach first.

Mr. Wilson: Wasaga Beach is an easy problem. They've spent the money; you just have to pay them back.

Just harping on this for a minute—and I will ask Mr. Smitherman. Not really being too critical here, the way it's set up, your ministries—for instance, the Ministry of Health—don't even allow hospitals to really go to the functional planning stage, which is a fairly preliminary stage before you put a spade in the ground, because they keep referring us over to your ministry. I suspect a bit of that is shuffling chairs on the deck of the Titanic, as they say, or buying a bit of time for the Ministry of Health. But these people raised over $13 million, when everybody said it couldn't be done, from a relatively small community and a farming community. It's a strategically important hospital. It will never be closed in the history of the province; it will only expand, mainly because of the terrible carnage that we see on a weekly basis on Highway 10. As I say, it's the only hospital between Owen Sound and Orangeville.

The fact of the matter is, they would like to go ahead. It wouldn't require a cash flow this year, really, from your ministry, out of the capital plan. It wouldn't require anything for maybe three or four years in terms of actual cash flowing for construction. They would like to get moving to the planning stage. It seems to me it's good politics. They'll be busy for the next year doing their functional plan.

How do I move that forward? What's your best advice? And can Dr. Hamilton Hall and Pat Campbell, the administrator of the hospital, and just a small group come down and see you? Will you see them and give them advice first-hand? They really have done a tremendous job. This is an area that probably won't even be in my riding next time around, but it's a strategic hospital and it's needed in terms of the trauma that occurs on Highway 10 on a regular basis.

Hon. Mr. Caplan: It certainly will be their loss if they do not have you as their member, Mr. Wilson. But I would say I would be delighted—

Mr. Wilson: That will be in my campaign brochure, I guess.

Hon. Mr. Caplan: I would be delighted to receive the folks from Markdale, to sit and chat with them to find out where they are.

I want you to know that I truly appreciate, whether they are large donors or individual community members, people from all walks of life who step up to support the construction of local hospitals, to support this kind of program. These are the kinds of things which are hubs of community life, which are major drivers, whether it's public policy or just what it is we are working to achieve, broadly speaking, as far as excellent health care, as far as smaller class sizes and investments in education, whether it's elementary, secondary or post-secondary, or whether it's economic prosperity.

Government is a partner with the local community, and I want you to know that we have in no way, shape or form any desire to see things be impeded. In fact, we are doing everything we can. We are scheduling realistically and responsibly what we can to get things moving along. It is through the leadership of Premier McGuinty and through the support of Finance Minister Sorbara that we are having the resources available, and I believe also the leadership to configure the government in such a way as to unblock or to move things where I know there have been very good intentions in the past and there have been many attempts—in fact, some of the foundation pieces were laid by your government and the NDP and Mr. Hampton's government in order to help us to move forward. I say most sincerely that we are building on some of those foundations in order to move these projects ahead. So where we can meet with, co-operate with and partner with local communities, I am very happy to meet, to discuss and try to figure out a methodology.

We will be confirming in this coming year the budgetary policies and the capital plan for the province. We are also adding subsequent years to the five-year plan. We only have an outlook to 2010. We wish to add subsequent years to schedule and to figure out financial arrangements so we can move some of those projects ahead too.

Mr. Wilson: I thank you for agreeing to meet with the folks from Grey county, Grey Bruce Health Services and Markdale Hospital.

In the three minutes I have remaining, another project is Highway 26. As you know, I've raised it many times in the Legislature. It's the realignment of Highway 26

between Stayner and Collingwood. The carnage on that road—I think since 1989, we've had over 435 casualties, many of that number being deaths. The realignment got started in 2003. We did land acquisition in 2001-02. It's about a $33-million or $34-million project. Unfortunately, in June 2004, the summer after you were elected, you took the bulldozers off the road. We have a wonderful aerial photograph hanging up in town that shows the realignment half done and the existing road that's still there. How do I get that project moving, given that I don't think any government in the history of Ontario has ever—and it's a 6.7-kilometre project. It's pretty small. I think you guys pulled the bulldozers off there last summer out of politics and spitefulness.

I met with senior MTO officials from the town of Collingwood, the town of Wasaga Beach, the Town of the Blue Mountains and Clearview township yesterday. Everybody wants this project to proceed. It's passing strange that you would pull the bulldozers off in the middle of construction season last year. What are your plans to move forward on that, given that all of the officials I talked to at MTO say it's your ministry that has to give the green light?

Hon. Mr. Caplan: I want to be very clear; in your remarks, you suggested some spiteful element. I want to assure you that was not the case. My understanding is that the construction of Highway 26, the realignment project between Wasaga Beach and Collingwood, was planned to be completed in a number of phases. The first phase was completed in fact in the summer of 2004. I understand that the Ministry of Transportation and the minister were called before estimates, and you could have an opportunity to probe the minister directly, if you so wish, Mr. Wilson, and talk specifically about the project. My understanding is that the Ministry of Transportation is currently completing the design for the next phases of construction, as well as continuing work on the projects for the Highway 26 corridor. But timing—

Mr. Wilson: I just want to save you from reading that briefing note into the record, with all due respect. It's not right. Your own ministry officials, off the record of course, will agree that it's just not right. They're not doing anything. You've cancelled the project. Nobody understands it. It's a safety issue, not a political issue. If it was political, we'd have done the whole thing in the year 2000. The fact of the matter is, we budgeted this thing and your own Minister Takhar admitted in the House that we fully put the $33 million in the 2000 budget. It's been spent elsewhere since last year. I think they've spent about half of it on half the work they've done so far. The briefing notes aren't right and somebody's spinning a tale here.

The Vice-Chair: Mr. Wilson, your time has elapsed. If the government would like to share minute or two, that's up to them. It's the government's rotation now, and with that—

Ms. Caroline Di Cocco (Sarnia–Lambton): We'll pass it over to the minister.

The Vice-Chair: Very good. You have approximately 20 minutes, Minister.

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Hon. Mr. Caplan: I want to thank the government members for allowing me the time to make some closing comments. First of all, Mr. Chair, I want to thank you and the committee for taking the time to chat with me and offering me an opportunity to provide some insight and some comments into the Ministry of Public Infrastructure Renewal. We're quite proud of the work we've done. We have covered a lot of ground. I want to begin my closing remarks by thanking the committee for the opportunity to appear before you to explain the issues Ontario faces in creating the public infrastructure we need and to describe the actions the government is taking to deal with those issues.

In particular, I want to acknowledge the importance of the opposition members in the proceedings. The purpose of this committee is to scrutinize the way we spend the public's money and therefore uphold the public trust, to make sure we do it wisely and carefully. The loyal opposition makes an important contribution to that process. We have a common purpose and a common responsibility simply to serve the public, and that takes precedence over any political disagreements about the way the purpose is accomplished. And I wish to acknowledge my colleagues on the government side and thank them, too, for their participation.

You know, Mr. Chair, a lot of work we do in government is not very glamorous. It takes places outside of public purview. It does not attract public notice or public comment, but it is important nonetheless. Our government prides itself on doing the right thing, even when we don't get much public recognition for it. You and this committee are doing the right thing by maintaining our commitment to the democratic process, even if no one notices. It is simply part of service to the public that we all promise to perform.

I also wish to mention the honourable Chairman of this committee, who handled the proceedings with evenhandedness, fairness and grace.

For my part, I wish to reiterate our commitment to respond promptly and fully to the questions the committee has raised. I believe in transparency and openness in government, and we will follow through with that commitment. We are giving expression to the belief in transparency and openness in the way we are proceeding to build the infrastructure that the people of Ontario need, a topic I will return to in just a moment.

In my opening remarks, I described some of the challenges we face. There have been decades of neglect and underinvestment, stretching back to the 1980s. Because of that neglect and the failure to maintain a decent state of repair in public facilities, we now face a massive repair bill. We didn't maintain our assets when we could have done it cheaply, and now we have to fix them when it is more expensive. It is part of the price we must now pay for the short-sightedness of our predecessors of all political stripes.

Parts of our infrastructure are simply wearing out. Some of our water pipes in cities like Ottawa and Toronto went into the ground before the turn of the

century—that's the 19th century. At least one city—I believe it's Kenora—is still using wooden pipes. One of our most important highways was named to commemorate Queen Elizabeth—not the current Queen, but her mother. Some of our schools were built in the 1920s, and so were some of our hospitals. Once they were modern, new facilities where our grandparents got treatment; now they treat our children and grandchildren but they are no longer new or modern. We need to repair what can still be fixed and to replace what can't.

Then we must build new infrastructure to accommodate the demographic changes inevitably coming to Ontario. Over the next 25 years, an estimated four million new people will come to live in Ontario, about 85% of them in the greater Golden Horseshoe region centred around Toronto. And that's great news. It will help to sustain our economy. There will be almost two million new jobs created and it will cement our position as a strong competitor in a global economy.

The potential bad news is that we have to build the public infrastructure that those people will need—roads, bridges, schools, highways, hospitals, universities, waste water treatment plants and the like—but we have to start building it now. It takes a decade or more for a major infrastructure project to go from conception to completion. Within two and a half decades we will add the equivalent of Vancouver, Edmonton and Calgary right here in southern Ontario. We are falling behind, and every day we wait it makes it more difficult and ultimately more expensive to catch up.

We need to repair and modernize the facilities we have, we need to build new facilities for the future and we need to take the steps to accommodate our growing and aging society. I want tell you, Mr. Chair and members of the committee, that none of this will be cheap. The most common estimate of the investment required is $100 billion. I've come to believe that that estimate is low. So one of the crucial issues our government, any government, faces is simply, where can we get the finances to do the job that's required?

Developing mechanisms to provide predictable, sustainable funding for the infrastructure we need is a major challenge. We need the infrastructure. It is absolutely essential to our economic success, and we cannot put it off any longer. But the investment required is beyond the capacity of this government, or of any government, if we rely on traditional methods of finance alone. That is the challenge that the Ministry of Public Infrastructure Renewal has been given. In the balance of my remarks, I will describe how we are planning to meet that challenge.

There are two elements to our plan to renew the public infrastructure of this province. They're equally important, in the sense that we must do both more or less simultaneously. The first is reforming the method we use to procure, finance and manage public assets. The second is a rational, coherent and comprehensive plan to coordinate virtually all public capital investments so that we build the right things in the right places, to restore what we have and to create what we need for future growth.

Let me take them in order, although they are going forward at the same time.

We were chosen almost two years ago by the people of Ontario to bring real, positive change to government. One of the most important of those changes is in the process we have developed to procure, finance and manage public infrastructure. There is a new way of doing business in Ontario. It is characterized by openness and transparency in building public projects; by careful management of the procurement process to get a fair deal every time; by careful management of the construction process so projects come in on time and on budget; and finally, by careful management of the resulting public asset so it lasts longer and performs better.

We will also broaden our strategy to encompass partnerships with other governments and with other public agencies like hospital boards and universities so that we work with a common set of priorities toward a common set of outcomes.

Over the next five years, the government and its partners will invest more than $30 billion in public infrastructure. That is the first step in a long-term plan to restore our public facilities.

That investment is accompanied by major improvements in the processes we use. All projects in which there is a substantial provincial interest, which means all projects of any size, will be subject to the province's infrastructure planning, procurement and management framework, a set of policies and procedures that dramatically improves the infrastructure process.

And because the challenge of infrastructure deficit is so formidable, we have also developed more flexible and better ways to manage public investments in infrastructure. We will look for innovative ways for financing and for paying for the infrastructure we need. But make no mistake: The government will continue to play the leading role in funding public infrastructure. Of the more than $30 billion the government and its partners plan to invest during the next five years, more than 90% will be direct public investment. But we will also be looking to pools of private capital, like public pension funds, and to long-term financing arrangements that will allow us to build the facilities we need, when we need them. We call this alternative financing procurement, or AFP.

There have been a number of questions by committee members and by others on alternative financing, especially as it applies to hospital projects. I want to deal with those questions as directly and as carefully as I can. I want to ensure that there is no confusion about what we intend to do and how it affects public infrastructure or about what this form of financing would mean for the people of Ontario.

Let me summarize the most frequently asked questions:

(1) Will alternative financing cost more, because the government can borrow money for less than any private sector consortium?

(2) Will alternative financing projects mean that the government will be making secret deals with the private sector?

(3) Will people lose their jobs because alternative financing means rewriting collective agreements?

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(4) Will alternative financing mean that the government will be allowing private sector companies to earn excess profits?

(5) Is alternative financing just another name for privatization and P3s?

I want to answer those questions.

First, it is only superficially true that government can borrow at a lower rate than the private sector, although that would not be true much longer if we borrowed at the pace set by previous governments. Standard and Poor's estimates that Ontario's total indebtedness as a percentage of GDP is now around 27%, which is very high in comparison with other jurisdictions. British Columbia, for example, is around 19%. The deficits your governments accumulate don't disappear when you do. They hang around the necks of our children and grandchildren.

For now, the government can borrow at a marginally lower rate than the private sector, and that is only one of the factors that affect the total cost of infrastructure. But it isn't the only factor, and it isn't the most important. Keeping the lid on cost overruns and poorly estimated projects is much more significant. The government has historically done that poorly, and the private sector has historically done it much better.

For example, the previous government started a hospital project in one Ontario city that was initially estimated at less than $120 million. It has now been completed one year behind schedule. The cost has ballooned by more than double to more than $230 million, and the public is on the hook for every dime of that cost overrun.

The fact that the government could borrow at a lower rate than private contractors is interesting but irrelevant. Private contractors have always built public infrastructure; they will continue to build public infrastructure. The only difference is that we are now getting better deals, and if the cost of the projects go over budget, we the people of Ontario don't pay for it. That risk is transferred to the private sector.

The other objections raised about alternative financing are equally nebulous. Will it lead to secret deals? No. Part of the process is a requirement binding all parties that makes contract details public documents. These deals will also be open to Ontario's Auditor General to ensure that the public gets the best value for money. The entire process will be fair, open and transparent, and the mechanisms are in place to make sure that it is.

For example, we are building a hospital in North Bay. All of our requests for proposals related to the project are available on-line through the public procurement Web site. We have provided this information to the Canadian Union of Public Employees, which represents workers at the existing hospital. We haven't signed any final contracts yet using alternative financing. When we do, we will make them public.

Will alternative financing cost people their jobs? No. Existing union contracts will be honoured in every case. In fact, I believe it will lead to more jobs, because more projects will be built sooner. There will be more jobs after the projects are completed, and there will be more jobs during the construction phase.

One of the issues with alternative financing is that we can't move forward as quickly as we want because there are not enough skilled tradespeople to do the work. Simply put, there are more jobs than there are people to fill them, which is one of the reasons the construction unions are strong supporters of this approach.

Finally, some of the more radical critics say that alternative financing is just another name for privatization, or P3s. Let me be unequivocal about this: Core public assets such as hospitals, schools and water systems will always be publicly owned, publicly controlled and publicly accountable. There is no transfer of public ownership in alternative financing and procurement. To suggest otherwise would simply be fearmongering. The most direct comparison is taking a mortgage on your house to renovate the kitchen. The contractor who installs the new cabinets doesn't end up owning your home, and neither does the consortium that renovates a hospital.

Ontarians are coming to realize that we do not face a choice between building the projects we need now using alternative financing or building them now using traditional financing methods. Our choice is between building now with alternative financing and procurement or delaying until some day in the indeterminate future when traditional methods will allow us to go forward. Given the financial conditions that past governments have caused, that day is not near.

Our economy and our way of life depend on infrastructure that is modern, reliable, efficient and affordable. We can no longer afford to plan and build infrastructure using the slapdash and improvised methods that have been used in the past. We need to plan carefully and thoroughly what we are going to build so that we create real assets, not white elephants. We need to coordinate infrastructure investments across the broader public sector so we are all rowing in the same direction. We need to change the planning horizon from the year-by-year and ministry-by-ministry approach the government has traditionally taken to one that more closely matches the time required to build and the time during which we will be using it. That time is measured in decades, not years.

We have begun that process with the ReNew Ontario strategy that my ministry released earlier this year in conjunction with our provincial budget. But we have only begun. To paraphrase Winston Churchill, this is not the end or the beginning of the end, but it may be the end of the beginning. We are now beginning to build, not just for our needs today but for the needs of our children and grandchildren far into the future.

ReNew Ontario, the government's five-year $30-billion infrastructure investment plan, includes both long-overdue projects and urgent new initiatives. It focuses on the key priorities of health care, education and economic prosperity. It includes more than $11 billion for public

transit, highways and borders, more than $10 billion for schools, colleges and universities and $5 billion for hospitals and other health care facilities.

All of the infrastructure investments will be paid for with public dollars, but the financing for some large projects will come from the private sector. All of that financing will be repaid from public funds over time. All major projects delivered through the alternative financing and procurement models will be subject to the principles of our infrastructure policy framework, Building a Better Tomorrow, to ensure that all of our infrastructure investments serve the public interest.

The funding for these projects includes:

—$18 billion of the province's own gross capital investments over the next five years, including federal flow-throughs. This includes $3.7 billion in gross capital investments in 2005-06 announced in the 2005 provincial budget.

—$5 billion in capital funding through operating grants to long-term-care homes for per diem payments and to school boards. That does not include funding for the Good Places to Learn initiative and for university expansion, which may be as much as $4.8 billion or more.

—Approximately $2.3 billion to $2.5 billion for projects using alternative financing and procurement methods, a small but vital part of the overall picture.

ReNew Ontario is a strategic five-year infrastructure investment plan, the first in our province's history. It concentrates on investments in areas that Ontarians have said are their priorities: health, education and economic prosperity.

By the year 2010, Ontario and its partners will invest approximately $5 billon in health care facilities to reduce waiting times, provide better services in high-growth areas and modernize older hospitals. Some highlights of the plan include these projects:

—Funding to start or complete 105 hospital projects that will expand and/or upgrade existing hospitals and build new ones;

—More than $150 million over five years to improve cancer treatment and expand diagnostic facilities.

—Nine new and seven upgraded MRI machines will be operating by the end of this fiscal year. Together, they will increase the number of MRIs by 15%.

—The number of doctors graduating each year will increase by 15%, starting in 2011-12.

We're also investing in education, and these investments are absolutely essential for our continued economic success. Our continued economic success is based upon the knowledge and skills of our people, and the very nature of knowledge is that it changes rapidly. Manual skills change very slowly. Socrates was a stonemason. That's how he earned his living, in fact, and Socrates the stonemason would still feel very comfortable in a modern stonemasons' yard. But Socrates the philosopher would be totally baffled by both the concerns and the tools of such key disciplines of modern philosophy as symbolic logic or linguistics. Our task is to prepare our young people for the knowledge-based jobs of tomorrow. By investing in education, we equip ourselves with the skills we need to compete in the global economy. By 2010, Ontario and its partners will invest more than $10 billion in elementary and secondary schools and in post-secondary facilities.

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Some highlights for the committee:

Over the next five years the Good Places to Learn initiative will provide annual funding to school boards to enable them to undertake approximately $4-billion worth of projects to address the backlog of repairs and new school construction needed in the system. Approximately $1.4 billion will be invested over the next five years for planned school construction and to accommodate projected new enrolment growth. In addition, another $1.5 billion will be provided to school boards over the next five years for ongoing renewal of school facilities. Approximately $1.8 billion will be provided over the next five years to support school construction already completed, and $540 million is being invested to renew university and college facilities and buy new equipment, including $250 million in one-time investments in 2004-05.

Over the next five years, $600 million will be invested in a major expansion of medical and graduate school space. Graduate education will increase by 14,000 students by 2009-10, and 15% more doctors, as I mentioned earlier. This is in addition to the first freshman class of future doctors who enrolled in the Northern Ontario School of Medicine this fall.

The Vice-Chair: Minister, you've run out of time. If you could wrap it up quickly, I'd appreciate it.

Hon. Mr. Caplan: Mr. Chair, I am certainly cognizant of your time. The balance of my remarks relate to investing in the economy. I just will very quickly wrap that up and come to a conclusion.

The students who benefit from those investments will enrich our society, both in individual and collective terms. They will contribute to an enlightened society and a prosperous one. But there are other investments we must also make to ensure economic success. Public infrastructure, including efficient transportation and transit systems, is essential to a robust economy. In addition to investments in health care and education, which improve our economy, Ontario and its partners are making strategic infrastructure investments that will have a substantial impact on our economic prosperity and quality of life. By 2010, Ontario and its partners will invest $6.9 billion for highways, border infrastructure and other transportation projects. These include accelerating the four-laning of Highway 69 between Parry Sound and Sudbury, and Highway 11 between Huntsville and North Bay. In southern Ontario, 22 new highway projects will focus on areas with high traffic volume and significant safety issues. Some $638 million to relieve congestion at borders includes $300 million to support improvements at the Windsor gateway and $323 million for improvements in Niagara and, Ms. Di Cocco will be interested to learn, the Sarnia border crossings as well.

Another $4.5 billion will be invested in public transit, including $3.1 billion to improve and expand public transit, including major investments in GO, the TCC and the O-Train, and $1.4 billion to improve 83 transit systems in 110 municipalities through the provincial gasoline tax.

Mr. Chair, I'll conclude my remarks. I had a little bit more, but I think it's important to note that those are all important achievements and I am happy to acknowledge the hard work and dedication of my ministry staff. I especially want to thank, here and now, Deputy Minister Geoff Hare for his leadership over the past two years in bringing us to where we are, and the staff at my ministry, without whom all of this work would not have been possible.

This work is an important foundation for what we are going to accomplish within the next two years. But now we must turn from planning to implementation, from laying the foundation to building the house. That is the task that will occupy the Ministry of Public Infrastructure Renewal and our government next. I want to assure you, Mr. Chair, and all members of this committee that when I return to this committee next year or the year after, I will have much progress to report. We are beginning a renaissance of public infrastructure in Ontario. It is an exciting time, and there is a lot of work to do. In the coming months, I look forward to working with all members of our Legislative Assembly to get this job done.

Mr. Chair, thank you very much and thank you to the members of this committee for having me here to speak with you today and yesterday.

The Vice-Chair: Thank you very much, Minister, you and your staff. I appreciate the information you've shared with the committee. As you understand, there are a couple of questions from research that are still outstanding. The committee looks forward to receiving those comments.

This ends the public presentation from the Ministry of Public Infrastructure Renewal.

Is the committee ready to vote on the estimates of the ministry? I have three votes.

Shall vote 4001 carry? In support? Carried.

Shall the estimates of the Ministry of Public Infrastructure Renewal carry?

Shall I report the estimates of the Ministry of Public Infrastructure Renewal to the House? That's carried.

That ends the business and review of this ministry. This committee will stand recessed for five minutes, when we will entertain the Ministry of Health.

The committee recessed from 1016 to 1029.

MINISTRY OF HEALTH AND LONG-TERM CARE

The Vice-Chair: Good morning. This committee reconvenes for the intention of reviewing the Ministry of Health estimates. Welcome, Minister and staff. We look forward to your presentation. It's your time.

Hon. George Smitherman (Minister of Health and Long-Term Care): Thank you very much, Mr. Chair, fellow members from all sides of the House and members of the public.

The Vice-Chair: Just one moment, Minister. Procedurally, there's one small but glaring question. There's some question as to whether or not we need the Minister of Health Promotion to attend these proceedings this afternoon. Any questions?

Ms. Di Cocco: I think it might be possible at the end of the seven and a half hours if there are questions that come forward during this session, so that we don't have a minister sitting here unnecessarily. Would that be possible, Chair, if it's required for him to come in, if there are questions for him specifically?

1030

The Vice-Chair: That would affect the ministry's overall seven and a half hours of time allocated. Other members of the committee may wish to comment. The question before us is whether or not we want the Minister of Health Promotion to attend these proceedings at some time. Further questions?

Mrs. Elizabeth Witmer (Kitchener–Waterloo): No, that won't be necessary.

Ms. Shelley Martel (Nickel Belt): Because we don't have revised estimates, I'd like to get some information about what budgets and how much of the budgets have gone to this office. So either that can be given to us from the minister and the deputy during the course of this questioning, or we could set aside time for that so we can get that information later today or tomorrow within the seven-and-a-half-hour period. Perhaps the deputy or the minister can tell me if we can get that information from you during the course of these proceedings. If that's easy, that would work.

Interjection.

The Vice-Chair: The money set aside specifically for that program spending.

Hon. Mr. Smitherman: Yes, we'll undertake to do that. I don't know what shape and form it will look like, but we will, if it would be appropriate, figure out what that's going to look like in terms of a time frame and then make sure that you're aware of it, and you could balance that with the needs of the committee.

The Vice-Chair: Very good. So I guess at this time we don't need to put the Minister of Health Promotion on notice.

Ms. Di Cocco: Great. That's good.

The Vice-Chair: Is the committee agreed? Great, thank you. Proceed, Minister.

Hon. Mr. Smitherman: Thanks very much, Mr. Chair.

Fellow members from all sides of the House and members of the public, it's a very great honour for me to be here, appearing today before the Ontario Legislature's standing committee on estimates. It's also an honour for me to introduce two members of our extraordinary team, those people who do the hard work at the Ministry of Health and Long-Term Care, who weren't with us last

year. I'm pleased to be able to introduce Ron Sapsford, our new deputy minister, and in the end seat on the third row, over my right shoulder, is Dr. Joshua Tepper, the first assistant deputy minister for health human resources that Ontario has ever had. I'll be speaking a little bit more about Dr. Tepper's role in just a few minutes. I'm very, very hopeful, and I send this message to the people in room 230, that you'll get a chance over the rest of the course of our hours together to eat—to meet, rather; well, take your best shot—to meet other members of the team.

I'd like to say that however much some of my friends opposite might be hoping to make this a less than happy occasion for me, and I don't begrudge them that, it is a real pleasure to be here. I think that the estimates defence is a key part of what makes a democratic government work.

It's very fashionable today to talk about accountability in government. It's a term one hears so often that I sometimes fear it may lose a little of its meaning and importance, and that would be a shame, because accountability is everything in government. We were elected two years ago in very large measure because the people of Ontario wanted a government that would be accountable. They wanted a government that would take responsibility for taxpayer dollars, not one that would hide multi-billion-dollar deficits. They wanted a government that would make tough decisions if they were the right decisions, instead of a government that would always seek the path of least resistance. They wanted a government that would govern with an eye on the next generation, instead of planning for the next election. The people of Ontario put their faith in us and demanded in return that we be accountable to them for every decision that we make and every action that we take, and that's why I'm here. The estimates defence process opens the government up to public scrutiny, and we welcome that. At the end of this process, Ontarians will, I think, have been very well served. Their government will have been held accountable by them and by itself, and that's the name of the game.

I'd like to start today by taking you back almost two years to one of the very first actions that we took as a government, because it is in the context of Bill 8, the Commitment to the Future of Medicare Act, that everything we have done since should be viewed. Bill 8 enshrined the very concept of medicare into law. It enshrined the notion of equal access for all, and it made illegal the kind of two-tier, pay-your-way-to-the-front-of-the-line health care that the ideological saboteurs of medicare would like to see. Bill 8 embedded accountability into the very fabric of medicare by adding it as a sixth principle on top of the five in the Canada Health Act. Roy Romanow recommended that. Bill 8 defined us as a government in terms of our fierce commitment to the principle of a publicly funded health care system and our willingness to do whatever needs to be done to defend and promote that system. In the wake of the Chaoulli decision, I consider it more important than ever that we be seen and judged in that context. I'll have a little more to say about that particular Supreme Court ruling in just a moment.

Right now, though, I want to tell you where we are, halfway through the mandate of the McGuinty government, and a little bit about where we're going. I want to talk about our vision of health care. It's a vision of a system that will help keep Ontarians healthy, get them good care when they are sick and be there for their children and their grandchildren. Our plan for making that vision a reality is built upon three key priorities, which we have committed to deliver and which we are delivering: shorter wait times, healthier Ontarians and better access to doctors and nurses. In the process of implementing this plan, we are, in effect, also building a system where one really never existed before: one that is responsive to the needs of Ontario's communities and the people who live there, one that integrates to the benefit of patients and one that emphasizes accountability and transparency in a way that has never been done before in our province.

Let me start with wait times, a subject that has obviously generated a fair bit of hyperbole in this country in the wake of the Chaoulli decision. Wait times are a critical barometer in health care. If they're too long, your system is not working properly. The Supreme Court made that very clear for anyone who didn't already know it. But here's the thing: We did know it already. We weren't waiting around for the Supreme Court of Canada to tell us that wait times were a problem. We made our determination to shorten them a key part of our election platform, and we have been on that case particularly for the past two years. Our wait time strategy is designed to shorten wait times in five critical areas by funding an unprecedented number of new procedures, and then keep them shorter by building a system to properly manage them. That's something we've never had in this province.

Since taking office, we have funded 240,000 new procedures—nearly a quarter of a million—in five key, priority areas: hip and knee replacements, cataract surgeries, cardiac procedures, cancer procedures and MRI/CT scans. By way of example, if we look at the total number of MRIs we've funded since taking office in this province, we're talking about 116,745 more procedures, an increase of a whopping 42%. This is yielding results. Royal Victoria Hospital in Barrie estimates that wait times for MRIs have dropped there from 42 weeks last November to a little over 14 weeks in July. I've heard anecdotes of people in those communities who are now attending for MRIs at 2 o' clock in the morning, when before our government came to office, those MRI suites lay dormant and the lights were out.

Overall I'm sure we can all see what an extraordinary difference these investments are making in the lives of thousands and thousands of Ontarians. But we're doing more than simply funding new procedures. The increased volumes are attacking the symptom, if you will, but we are also tackling the overall problem. We're not doing that alone. To date, more than 200 doctors have worked on expert panels to create a template for better ap-

proaches to handling wait times right across the system. A critical part of reducing wait times and keeping them shorter is managing them, and as I said earlier, until now there really has not been a system in place for doing this. For example, we inherited a system where nobody knew—I know this will sound incredible, but it must be said—how many cancer surgeries were being delivered each year in Ontario. According to a survey we conducted a year or so ago, MRI wait times varied from four weeks to 50 weeks depending on which hospital you were at. That is not a system, that's a roll of the dice, and we're changing that.

For the first time ever, we're building a system in Ontario to measure and report to patients on a Web site about the state of wait times in this province, starting with our five key areas. I can tell you that within the next few days our wait times Web site will be featuring up-to-date wait times data broken out by specific procedure, by hospital and by local health integration network area. I wonder whether my friends can see what a hugely powerful tool we're placing in the hands of Ontarians with this Web site. Imagine, for a second, being able to tap a few keys and find out how long the wait is for a particular procedure at your local hospital. Imagine thinking to yourself that you don't really want to wait that long, tapping a few more keys and finding out that waits at the hospital an hour or so up the road are only half as long. You tell your doctor, get a referral to the hospital up the road and get your procedure in a more timely manner. This Web site will serve Ontarians well. It's a model of transparency, it will allow people to take control of their own health care and it will drive accountability into the health care system.

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Let me move on to our second key priority: healthier Ontarians. It should be self-evident that keeping people healthy is just as important as caring for them when they get sick. The best kind of health care system seeks to prevent illness in the first place, and that's the system we're proud to be building in Ontario. We demonstrated our commitment to that back in June, when Premier McGuinty appointed my colleague Jim Watson as Minister of Health Promotion. This is the first time this province has ever had a cabinet portfolio solely dedicated to promoting healthy living and illness prevention, because the fact is that Ontarians keeping themselves healthier is a key contributor to the overall sustainability of health care. This is something we all can and should do. It was certainly part of my motivation to compete in a half marathon this past weekend.

Since taking office, we have undertaken the most comprehensive changes to public health seen in this province since the 1980s. As my colleagues will know, Operation Health Protection, which we launched in June 2004, called for an increase in the independence and authority of the chief medical officer of health. Legislation to that effect passed last year, and I thank all of my colleagues who supported this bill.

The plan also calls for increasing public health capacity at the local level by raising the province's share of public health funding, which stood at 50% when we took office. That is being done. We are now responsible for 55%, and that will rise to 75% by January 2007.

We also now have the most comprehensive tobacco control strategy in North America. Again, I'd like to thank members from all sides who offered very strong support for these reforms. The smoke-free Ontario strategy features programs to prevent children and youth from starting to smoke, to help Ontarians who do smoke to quit and to protect Ontarians from exposure to second-hand smoke.

Thanks to the Smoke-Free Ontario Act, smoking will be banned in all enclosed public places and workplaces as of May 31, 2006—no exemptions. At the risk of sounding melodramatic, eight months from now this province will be a healthier place to live and to work. The Smoke-Free Ontario Act will also toughen laws on tobacco sales to minors. As of 2008, Ontario children will no longer be exposed to any visible tobacco product in almost any part of the retail sector. I'm very happy to note that, going forward, Minister Watson will be carrying the largest part of the tobacco file. That will be in his very capable and experienced hands.

Last year we introduced three new vaccines to protect children against meningitis, pneumococcal disease and chicken pox.

Fundamental to the notion of keeping Ontarians healthier is improving the care they receive in their homes and their communities. Our entire plan for health care is built on the understanding that the best health care is that which is delivered closer to home. So we are continuing this year with investments in community level care that are unprecedented in Ontario's proud history. We've made a record $1.46-billion investment in home care so that Ontarians can receive the dedicated, compassionate care they need and deserve in the comfort of their own homes. Our funding this year will help an additional 45,000 acute clients, who will be able to receive the care they need in the dignity and comfort of their homes instead of in hospitals. This will also allow hospitals to better provide the acute care services they are so good at providing.

We're making a 21% increase—an extra $91.7 million—in funding for community mental health services, which is a critical part of our health care system and one that was all too frequently overlooked by previous governments. Our investments include $27.5 million per year specifically to divert people with mental illness away from the criminal justice and correctional systems. The money will go to community mental health agencies across the province that will provide services to an additional 12,000 people.

We are continuing the revolution in long-term care with a funding increase of $233 million, or 9.4%, including 700 new beds and the continued hiring of new staff that was begun last year. The coming session will also see us introduce a new long-term-care homes act. It will be the cornerstone upon which we build a long-term-care system that will be a model for the rest of the country.

Moving on to our third priority, we have made great progress, since taking office, improving the access Ontarians have to doctors and nurses. There is no doubt that many challenges remain, but we have made significant progress that deserves more attention, I believe, than that which has been provided so far.

As I mentioned at the outset, three weeks ago, Ontario got a first: an ADM for health human resources who reports jointly to my ministry and to the Ministry of Training, Colleges and Universities. Dr. Josh Tepper's mission is to move us forward even faster. His time spent delivering health care in more than a dozen rural and remote communities, like Ignace, serves as his motivation to excel.

He'll be building on a few things where we should cut through the noise and take time to celebrate, because they're very impressive results. For example, the report by the Canadian Institute for Health Information indicates that in 2004, for the first time in a long time—perhaps ever—more doctors moved to Canada from abroad than left here; or the news from the College of Physicians and Surgeons of Ontario that we issued more medical licences in this province last year than we have in almost 20 years; or the fact that, according to the College of Nurses of Ontario, the number of nurses working full-time in Ontario went from an estimated 51.7% last year to 59% today, a number, by the way, that is verified by the Registered Nurses Association of Ontario. On the subject of full-time jobs for nurses, we've created 3,062 nursing jobs since taking office, and I'll have more to say about that in a moment. The fact is, we are making significant progress and the investments that we are making this year are designed to continue this trend.

As you all know, we reached an agreement last spring with this province's doctors, one that makes Ontario an extremely attractive place to practise medicine. It's a groundbreaking agreement that encourages doctors to practise in new and better ways—group practice being a key example—and rewards them and enhances their ability to provide comprehensive primary care to Ontarians. Under that agreement, fee increases totalling $200 million kick in on October 1. This money will go to support doctors working in group practices, more after-hour patient care and care for seniors.

We're increasing medical school enrolment by 15% over the next four years; that's 104 new undergraduate positions by 2008-09. We're also investing more than $16 million this year to increase family residency positions. By 2007-08, we will have trained 340 more family doctors in Ontario who will provide care to some 400,000 Ontarians.

Let's stop to celebrate this point. It was not very long ago in Ontario that family residency spots went unselected, as people chose instead to pursue specialties nearly exclusively. It is only through the efforts that we have taken to date to revitalize the role of the comprehensive family practitioner, to introduce new forms of practice like interdisciplinary practices, that an astonishing percentage of those residents in our system today supported our agreement with the Ontario Medical Association.

We're training more international medical graduates than ever before, giving many qualified people, who until now have had their dreams of practising medicine in Ontario frustrated, a crack at making their dreams come true. We need them. And while the situation is improving with respect to international medical graduates, we still have much more work to do. We've established a program with the College of Physicians and Surgeons to repatriate doctors practising outside Ontario who would like to work here.

In addition to ensuring that we have more doctors, we are increasing the access Ontarians have to them. We're creating seven new community health centres and five new satellite CHCs over the next two years, building on the 10 satellites currently being implemented. Community health centres are a critically important part of our community-based health care plan, delivering care to those people in our society who might otherwise have fallen through the cracks in our system. I am proud to be part of a government that is expanding a network of community health centres, something that has been long since overdue.

Of course, we are going to continue with the creation of our 150 family health teams. Next month, we'll be announcing the next wave of family health teams, building on the 69 that we announced last spring. Family health teams are the embodiment of the kind of primary care reform that experts like Roy Romanow have been calling for for years. They are groups of doctors, nurses and nurse practitioners working with other health professionals, ranging from mental health workers to pharmacists, to deliver the best kind of comprehensive care to thousands and thousands of Ontarians, many of whom might previously not have had access to a family doctor.

We increased funding for our hospitals by 4.7% this year. More importantly, we introduced multi-year funding that hospitals have said for many years they need to better plan for the future. It's just common sense. From here on out, hospitals will obviously be much better able to plan for their needs and the needs of their patients.

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We're also making an extremely significant investment in hospital infrastructure around this province. As part of our $30-billion ReNew Ontario public infrastructure plan, we will be investing approximately $5 billion over the next five years in 66 new hospital projects and in finishing 39 others. These projects will allow hospitals to upgrade and modernize, reduce wait times and provide better service in high growth areas.

Clearly, not every hospital that wants to launch a major capital project is going to be able to do so. That would simply be unrealistic, both in terms of our capital budget and when you consider the added operational costs associated with every new project.

All of these investments in hospitals, family health teams and community health centres, as well as community mental health and home care, will result in more jobs for nurses as we continue to build on the more than 3,062 full-time nursing jobs that I mentioned earlier we have created to date.

The situation with regard to nurses is pretty simple. They're the heart and soul of health care, and you can't have a health care system without them. So we are investing heavily in better education and professional opportunities for nurses, as well as safer nursing working conditions. I'm talking about mentorship programs and initiatives to provide late-career nurses with less physically demanding roles to keep them working longer and continuing education programs that will ensure nurses have the knowledge and skills that they need to succeed in a very demanding profession. We have invested $114 million in ceiling-mounted bed lifts and other safety equipment to reduce the risk of on-the-job injury. In short, we are working very hard to make the lives of nurses better and the jobs of nurses safer and more satisfying.

Ladies and gentlemen, I think I've given you a fair idea of the changes and improvements we are making within Ontario's health care system. I'd like to end by talking to you about a couple of very significant changes we are making to the system itself.

As I said at the outset, we are building a system that emphasizes accountability and transparency in a way that has never been done before in this province. The tool with which we're driving that accountability and transparency is the newly created Ontario Health Quality Council. As most of you know, the Ontario Health Quality Council was established as part of Bill 8, the Commitment to the Future of Medicare Act. The mandate of the Ontario Health Quality Council is to monitor the province's health care system and report to the public on access to publicly funded health services, access to doctors and nurses and the overall health of Ontarians.

What that means is that the council is going to tell the health care story to Ontarians in a way that has never been done before. What was previously an exclusive discussion, complete with acronym language barriers that was carried out exclusively sometimes by people like us in gatherings like this, will now be made accessible to anyone in this province who cares to pay attention.

The council is an independent body. It couldn't do the job we need it to do if it weren't. Just two weeks ago, we announced the 10 founding members of the council, 10 people who bring a tremendous range of health care knowledge to the council, as well as a fierce commitment to helping to improve Ontario's health care system. Their job is to shine a light on the health care system we're building and running on behalf of Ontarians and to give them a sense of how well we're doing. It's their health care system, paid for with their tax dollars. They own this system and, accordingly, they have a right to know how well their money is being spent. The Ontario Health Quality Council is going to deliver annual reports on how Ontario's health care system is performing and on the health of Ontarians. The first will be delivered before the end of this fiscal year.

One of the highlights for me of the upcoming session of the Legislature will be the introduction of our local health integration network legislation. It is something we have been building toward for most of the past two years, since we first determined that this was the direction we wanted to take health care in Ontario, because it's the right direction, though quite frankly it's a direction that previous governments have either been unwilling or were afraid to take.

We told the people of Ontario during the last election campaign that we thought the status quo in health care wasn't good enough, and they apparently agreed, because here we are. Thanks to LHINs, the status quo is no more. We launched our 14 new local health integration networks in June. They have already begun to create the culture for an ongoing dialogue among themselves, local health care providers and, more importantly, their communities, a conversation that has never taken place before. The legislation we are going to introduce, if passed, is going to grant them the power and authority they need to move from dialogue to action.

Local health integration networks represent a dramatic change and a significant improvement in the way we manage health care in this province. The simple fact is, health care in Ontario is a $33-billion operation, and as I have said many times, you can't micromanage a $33-billion operation from head office. It's not even sensible to try. You can shovel 33 billion bucks out the door, you can even point it, vaguely, in the direction that you want it to go, but to ensure that it does what you need it to do, to ensure that every community care access centre, every community support agency and every long-term-care home across this immense province gets a fair and equitable share of funding, to ensure the health care dollars are going to meet the specific needs of individual Ontarians and the specific priorities of separate communities, north, south, east and west, to ensure all that, you need good people in those communities on the ground, managing the system for you and for Ontarians. That's what local health integration networks are all about. They'll be there, in the community, engaging Ontarians, involving them in a broad conversation about their health care in a way that people at the local level have never been involved before, making them part of the debate and part of the outcome. Local health integration networks are going to help us build a system that has patients at its centre, to ensure that in an environment where there will always be fewer resources than we'd prefer, they are prioritized with patients and communities at the forefront in that discussion.

Now, it's not going to happen overnight. This will be an evolutionary process. We plan to take much of the power and authority that currently resides in my office, in the health ministry, team it up with the power to plan and to implement, and through the legislation, transfer it to our local health integration networks. It is community-based government, by and for the community.

Before I conclude, I'd like to say just a few words about the health care situation nationally, which I think is quite promising. I think this is a political era in this country at least partly defined by a collective will to work together to ensure that citizens from coast to coast have health care that they can depend upon. That's why first ministers from the provinces, territories and the federal government came together a year ago to sign a health accord that is designed to ensure Canadians receive the health care they need in a timely manner. It's why I have been working so hard with my provincial colleagues to come up with a partnership model that includes the federal government and drug manufacturers, to provide for Fabry's disease and other such rare diseases. It's why my provincial colleagues and I are calling on Ottawa to step up to the plate and take a partnership role with us in implementing the expensive drugs for rare diseases strategy, to help us ensure that people suffering from these rare diseases don't fall through the cracks. Health care is a provincial responsibility, but in our country, obviously, it's a national undertaking. I look forward to continuing to work with my colleagues across the country in honouring the spirit of that undertaking.

In closing, I'd like to repeat what I said at the outset: It's a tremendous pleasure to be here and an honour to address this committee. Looking back on the past two years, I could cite any number of individual health care accomplishments that I consider to be significant, but there is one overall achievement of which I am most proud: We've defined the problem, we've drawn up a plan, and the implementation is well underway. Between local health integration networks and the Ontario Health Quality Council, the system that delivers health care to Ontarians will never be the same again. With wait times coming down and access to doctors and nurses improving, we're building a system that is much more likely to meet the understandably high expectations of Ontarians, and they deserve no less. Thank you.

The Vice-Chair: Thank you very much, Minister. With that, we'll start the process whereby the opposition will have 30 minutes, followed by the NDP, who will have 30 minutes, to either make a statement or engage the minister in questions.

Mrs. Witmer: Thank you very much, Minister Smitherman, for your presentation. Before I begin, having normally sat in the chair that you occupy, I know how much work has gone into the preparation of these estimates, and I want to express my appreciation to the staff of the Ministry of Health and Long-Term Care. I know it's a big, big job, and I thank you for the work that has been undertaken. I also want to thank the minister's staff, because I know on their part it can be a very stressful, busy time as well. I appreciate that before coming in here today, there were hours and hours spent, and I do appreciate that.

Having said that, I was struck by your use of the words "accountable" and "transparency," Minister. The repetition of those two words really causes me to ask you this question. On page 4 you say that the people of Ontario demanded "that we be accountable to them for every decision that we make," and then you go on to talk about transparency. I just wonder if you could tell me—and I know there are others who would be interested in the response to this question—why you have made a decision not to provide funding for the Cambridge hospital project. Up until this point, there has been no explanation given to that community, despite the fact that they meet all of the criteria and all of the money is in the bank with their share. I think that's probably what is of most concern to people, that there has been no attempt at any explanation other than no.

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Hon. Mr. Smitherman: I think you had two points on this that are very important. The first is to say that when we talk about accountability and transparency, you can see through a variety of undertakings on the part of our government, particularly as it relates to the actions of the Ministry of Health and Long-Term Care, that we are creating a system in Ontario that lives up more to the word "system." As part and parcel of that, through the Ontario Health Quality Council, it will mean that Ontarians who right now suffer from information overload, often delivered in a fashion which is contradictory—what we're seeking to do is to give Ontarians more access to the discussion around health care so that they can hold their government more accountable, through the creation of a body that will have the responsibility for telling the health care story in a factual way but in a way that makes the discussion, the debate, more accessible. That's the fundamental delivery on commitment with respect to accountability.

The premise of your question with respect to Cambridge, not surprisingly, is all wrong. Firstly, if you want to talk about accountability related to Cambridge, then we can't go very far down the path without ducking the reality, which is that in the run-up to the last election, your party—you were not the Minister of Health at that time, but I believe you might have been the Deputy Premier—ran around Ontario heightening expectations with respect to Ontario's capacity to fund every worthwhile hospital project. I'm sure I'll have the opportunity to read into the record some of Mr. Tory's quotes confirming that that had gone on. He certainly delivered those very articulately in Cornwall.

I think I'll argue your point too with respect to Cambridge. The bottom line in Cambridge, and with all of these other projects where expectation has been created—artificially created, I argue strenuously—is that we know the Cambridge project is a good project, and it is not a matter of if, only when, in terms of our ability to support the move forward on that project. You say there has been no communication with Cambridge. Of course, this is inaccurate, as I took the opportunity a week ago yesterday to meet with the mayor, the hospital board chair and the hospital CEO. Subsequently I've been in conversation, as an example, with the regional chair to express our view that as a government we seek, as quickly as we can, to be in a position to support the important project in Cambridge.

But again, given your very role through the Health Services Restructuring Commission, which dramatically underestimated costs related to capital projects, you had an obligation as a government to complete all of this capital development by 2003. The obvious reality is that, in a similar sense to the operating deficit you left behind, there was a capital expectation created that was a deficit of its own. That has obvious operating implications as well through post-construction operating programs.

All of these things taken together create a fiscal situation in our province which we have worked very hard to address, and evidence is there today—as an example, on the deficit number—to show that we're making good progress against what was left behind. On capital, too, we're making very good progress, but at the moment we do not have the capacity fiscally, and probably from a construction standpoint too, to build every worthwhile project. The message I have worked hard to send to the people of Cambridge, and one which I'm prepared to send again today, is that we know this is a much-needed project, we know that good work has been done, and we will support that project when it is possible to do so.

If you wish to ask me more questions related to the project that we were able to support, which I believe is in your riding, it has very significant regional implications associated with it. But even while I will advance very positive arguments in favour of the projects that we are able to support at the moment at Grand River, I will not in any way do so with a view toward diminishing the need in Cambridge. We will continue to work toward a resolution in Cambridge. I have been clear in saying to all of those individuals that the ministry will bring the highest degree of creativity and openness to the work that we undertake as we seek to find the appropriate capacity to advance that much-needed project in Cambridge.

Mrs. Witmer: Thank you very much, Mr. Smitherman, although I would have to tell you I certainly don't agree with all of what you have just said.

I guess I would mention to you that all the recommendations that were made and all the approvals that were given were based on the recommendations of a very independent health restructuring commission, and I see the ministry and this government now making similar commitments to projects throughout the province; for example, the new Oakville hospital in 2009. Obviously, again, do you know what? The reality is, commitments are made. There is an expectation on the part of communities that governments will follow through. That hasn't happened.

But I think the people of Cambridge are also aware that there are new hospital projects that were never recommended by the commission that you are planning to fund now, so obviously your government has made some choices, and in making these choices, Cambridge is no longer a priority. That is regrettable, because we have an aging infrastructure. Unfortunately, money that was to be used in the operating budget is being used to repair an aging facility. It's going to be increasingly difficult for the dedicated, hard-working staff to be able to achieve the wait times that are being asked of them, to deliver the same number of services. The quality of care will remain the same because of the dedicated, hard-working individuals; however, the services and what happens there is going to change, and that is regrettable.

As you know, the campaign that took place in our community was one that was based on "One Voice, One Vision." The community made financial donations and the money is in the bank. The region was one of the few regions, I might add, in all of the province of Ontario that saw the need for more health services being so necessary that they had a levy and the municipality, Cambridge, collected from people. So there has been an overwhelming response. I know that in some of the projects you've announced, there has not been any fundraising taking place, or nothing in the way of the level of support.

So my concern is that these dedicated people will be asked to continue to deliver quality of care, which I know they can do, but obviously the number of procedures and the ability to meet wait times are going to suffer some consequence.

Having said that, I want to turn to wait times, because on pages 2 and 3 you talk about shorter wait times. I want to ask you, what are the benchmarks that the government is using? What are the targets that you are moving toward?

Hon. Mr. Smitherman: I'll take the opportunity to answer both sets of questions together.

First, let's not pretend here that the Oakville hospital wasn't on a list left behind by your government. You talked about HSRC and tried to separate yourself from the obligation—

Mrs. Witmer: No, we announced that.

Hon. Mr. Smitherman: That's right, so a list totalling $6 billion or $8 billion—$8 billion by the current estimate of the Ontario Hospital Association.

To your premise that other hospital projects don't enjoy community support, I found that a bit astounding, so I'm hoping you will provide me with some insight into those that you don't think had sufficient community support.

Mrs. Witmer: Financial support.

Hon. Mr. Smitherman: I'm not interested in the game of trading one of these off against the other. Like I said at the beginning, I can do nothing except positively acknowledge the good work of the people of the region in Cambridge. I've said very clearly that it's a project that we very much want to support and that we recognize the need for. I think evidence of our support for this hospital is that we put a brand new CT scanner in there just in the last number of months to address wait time challenges. I think that's important. On the issue of repairs there, we've been clear also in saying to the hospital that we're going to work with them and do what we can to address circumstances, even if that's on a more interim basis.

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On all these points, we've sought to say that in the circumstances, which we recognize are not ideal because

we cannot do everything that your party on its way out of office sought to create the expectation for, we will still, through ReNew Ontario, go to some extraordinary measure to address all that can be addressed.

With respect to your issue on wait times, if you read the conditions that came out of the First Ministers' meeting of last September, there are obligations on the provinces to establish access targets. Accordingly, our government will be fulfilling those commitments. I'm going from memory here, but I believe that that commitment is to do so by the end of December this year. That's something we are currently on pace to be able to do.

I can tell you that notwithstanding that, however, we've gone to town on addressing key wait-time priorities. I think that one that stands out with lots of evidence of exceptional progress—and this is a credit to a lot of people working out there on the front lines of health care, working shifts into the evening and through the night—is on access to MRI exams. We have increased access to MRI by 42% in the province of Ontario. We're always seeking to identify where additional resources are required to equalize the access that Ontarians enjoy to those services. That's a benefit that local health integration networks will enhance our capacity to do over time.

Mrs. Witmer: I guess you still didn't answer my question. We hear a lot about funding for additional procedures, but I want to know what your benchmarks are, what your targets are.

Hon. Mr. Smitherman: I did answer your question directly but I'll do it one more time. In keeping with the First Ministers' agreement, provinces were to have these established. There's a whole sequencing of events there. There is some detail that we'd be happy to offer if you haven't had the advantage of seeing that prior. Ontario will be in a position to confirm these by the end of December of this year—I nearly said "fiscal year"—by the end of December of this calendar year. That's entirely in keeping with the commitments that our Premier made on behalf of the people of Ontario and the First Ministers' accord.

Mrs. Witmer: I still don't think I have my answer.

Hon. Mr. Smitherman: It's forthcoming by the end of the year, in keeping with the First Ministers' accord.

Mrs. Witmer: Right. So basically, the public has not had the opportunity to see what your benchmarks are and we don't know what your targets are, and we're not going to see them until when?

Hon. Mr. Smitherman: You're not going to see them for a few more months, in keeping with the First Ministers' accord. However, within the next number of weeks, Ontarians will begin to see what the current state of wait times is. We will be in this position, for the first time in Ontario, because we've been building a system that you, as the longest-serving minister in the Conservative government, chose not to address. It is a system that accurately, across a broad number of things, actually captures information and makes it available to the public.

Talk about transparency. Within a couple of weeks in Ontario, every Ontarian who has access to a computer, which, because every library has a computer, is getting to be pretty extensive, is going to be able to go on there on a hospital-by-hospital basis and take a look at what actual wait times are.

Yes, we are taking advice from a wide variety of groups around the appropriate evidence-based indications for benchmarks and for access targets, and those are forthcoming. But we have not waited. We have obviously already, by increasing procedures by almost a quarter of a million, begun to address these wait times head on by doing two things at the same time: increasing volumes, and asking panels of experts—doctors, who have themselves become tremendous leaders of change in the hospital environment—to help us on an expert panel basis to do a bunch of the work that, frankly, I say to the honourable member, could easily have taken up some of her time and energy when she was Minister of Health and didn't.

We're working hard to build a system to accurately capture this information and make it available to Ontarians and to learn the lessons, as we go through these on a case-by-case basis, that can be applied to all procedures across the province. We're addressing the symptoms through volumes, and we're getting to the heart of the matter by working with experts to change the way we practise the delivery of many of these services, especially in the hospital environment.

As far as I can tell, this has been an amazingly beautiful awakening for a lot of clinicians in Ontario who have actually actively been engaged by the ministry.

Dr. Alan Hudson, Hugh MacLeod, the head of our health results team, and one of our associate deputy ministers, Dr. Peter Glynn, have been working and have helped Ontario become, in less than two years, a foremost leader in the country around the issue of wait times. This is one more example of the concentrated effort of our government, where we will move Ontario from worst to first.

Mrs. Witmer: As the minister well knows, we were pleased to be able to set up the Cardiac Care Network, which actually started dealing with this whole issue of procedures, wait times and targets. Since your government has assumed office, "wait times" has become the buzzword, not just in Ontario but throughout Canada and in fact throughout many parts of the world. For the public, this is now the popular phrase that people are using. It really is "wait times."

Until we actually see what the benchmarks are that you're going to be using and what your targets are, it's not of much value. The public can go and take a look at wait times, and I know that I've taken a look at some of the wait times when I've met with individuals. I guess what I hear you saying is that sometime toward the end of 2005, we are going to see the benchmarks that the government is using and also what the targets are going to be. Is that accurate?

Hon. Mr. Smitherman: Part of that is accurate. I'm not one of those who is prepared to usurp the voice of Ontarians and describe as "useless" information that tells them directly what level of service they can expect in

their local hospital. I don't characterize that as information that's not helpful in the piece. I take your point with respect to benchmarks and access targets, of course; I understand where you're coming from. But I would just say, in an attempt to lay a question on that, I really don't think that we should characterize making a whole bunch more information available to Ontarians in a timely way about the actual operation of their hospitals as useless.

We kind of feel pretty strenuously that the health care discussion has not necessarily been one that has allowed many Ontarians to access it, because a lot of times we use acronyms and big numbers that can sometimes confuse a storyline. Putting a lot more information in an understandable fashion in the hands of Ontarians we think is a really essential element of the discussion.

On this issue of wait times, you said that it's become commonplace to talk about it; yes, it has, because our party, the first in the country, ran on wait time reductions. Subsequent to that, the federal Liberal Party ran on a similar platform. It's fair to say that here in Ontario—this is, I think, the primary answer to questions around Chaoulli. We view the Chaoulli decision more or less as a validation that, as a government, it's appropriate for us to be focusing on issues respecting wait times. That's why we campaigned on it and that's why you've seen an unprecedented effort to address wait times exactly consistent with what we campaigned on.

We took a campaign promise to the people of Ontario that said we would reduce wait times in these five key areas, areas that have a high degree of disability, much of it associated with aging, and we have addressed already, by an increase of 240,000 procedures, many of those backlogs. So yes, "wait times" is very current language in the discussion around health care in our country, and our party put it there. We campaigned on it.

Mrs. Witmer: The wait time information is important to the public, but they also need to know that if another hospital has shorter wait times, then obviously they have the opportunity to access that hospital in order to have the service provided to them.

You mentioned that you focused on these five key health services. We do continue to hear from people about the fact that it's having an impact on other types of surgery, and I'd like to know what is happening to the wait times for other services.

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Hon. Mr. Smitherman: I think there are two things that need to be said. Firstly, as we begin to collect timely data—you must remember. I have lots of former Ministers of Health here. One of the great frustrations I've experienced is that access to timely and reliable data is—

Mr. Wilson: And future.

Mrs. Witmer: And future. Did you hear that?

Hon. Mr. Smitherman: Yes, OK. That's right. This will help your electoral fortunes. Jim Wilson has just said that he's going to be the next Minister of Health in the province of Ontario.

Mrs. Witmer: I think it will help.

Hon. Mr. Smitherman: Yes. I felt the whole system cringe.

When we identify wait time differentials, of course it's going to encourage a debate. When two hospitals have a different circumstance, there will be a variety of questions that are asked. But there is an important tool that we are in the midst of building that is going to be essential in providing equitable access to service to Ontarians, and that's local health integration networks.

I'll give you an example. It has long been known, but operated under really as a theory—hard to prove—that in the Champlain district, which includes notably the city of Ottawa, and other cities, like Cornwall, that they lag behind on access to hips and knees. Accordingly, therefore, as we are increasing access to those types of services, we seek to do so in a fashion which provides a more equitable balance. So Champlain would receive a larger allocation for hips and knees—in fact, to date, we have saturated all of the capacity that is available for hips and knees in the Champlain district, to the point where we've started to run into other challenges around health human resources, as but one example.

On the issue of wait times in other areas, I think the first thing that needs to be said, and said bluntly, is that this is, in a certain sense, a theoretical argument. The reality is that our wait time strategy cannot be associated with anything beyond the fact that in five key priority areas we have identified new resources and funded those at 100%. We have bought every new procedure, every new advance along the wait time commitments that we have made. We have put additional resources into the Ontario health care system to achieve that, alongside other increases very broadly across the health care system—to enhance the capacity of hospitals, as an example—to focus on an acute care mission, because we've taken back so much of the responsibility that they had for the provision of services that are best provided in the community.

I think that any government should fulfil the commitment that it makes with respect to wait times. We made that with respect to five of them, and we've paid for every new procedure there. We have not rededicated resources from other elements of the health care system to that wait time strategy. Each and every penny for every new procedure was a new penny.

Mrs. Witmer: I have just one point I want to make, and then my colleague Mr. Wilson does have a question.

You know, we have talked a lot about wait times, and the reality is wait times have been a big issue for governments of all stripes for a number of years now. But as I say, at the current time, the awareness is even more heightened as far as the public is concerned. But I'd just like to remind you, Minister Smitherman, that it was our government that started to address that issue. I talked to you about the Cardiac Care Network. I would just like to remind you that as a result of that particular initiative, we were able to reduce the wait times for cardiac surgery by 50%, which is a very significant number. I hope that when you continue to move forward, you will be able to achieve similar results.

Hon. Mr. Smitherman: I think that on very many occasions we've acknowledged that work, as an example, related to cardiac care has been an influence in places like Saskatchewan, but we've gone many steps beyond that by now.

You used the word "awareness" again in your question, and that's why I'm still a little bit dumbfounded that you don't think that it's pretty exciting that within a few days we can go live on a Web site that will give Ontarians never before seen, unprecedented access into real, genuine, timely, verifiable information about what's actually going on in the hospital around the corner, because it's all part of feeding, if you will, that sense of awareness and trying to infuse a greater degree of public participation in the discussion about a public health care system.

But yes, of course, many of the things that we're able to make progress on relate to what I might characterize as the institutional culture and capacity of the health care system. That's on the good side and it's there on the challenges side as well. Maybe it's time that we all stop pretending that, in a four-year window, any one of us can make every move, that there is enough energy or resources available to take every situation that's bad and make it good. You must have priorities in a system this large. I am very proud that as a government we've addressed the priorities that we campaigned on, on the mark.

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

Mr. Wilson: Thank you, Minister, for appearing today. I just want to correct the record: I'm not promising or planning to become Minister of Health again, so you can all breathe a sigh of relief at the back there—

Hon. Mr. Smitherman: And you too.

Mr. Wilson: —and in room 210. I see you've lost your hair. I certainly lost mine during my two years as Minister of Health.

I just want to ask about a local question. A couple of weekends ago we celebrated at Centre Grey health services, the Markdale hospital site, the raising of over $13 million. In fact, Dr. Hamilton Hall, who headed up the fundraising campaign locally, who has spoken to you briefly about the new hospital for Markdale, tells me they've actually raised $13,131,355, which is pretty amazing. When they first approached the Ministry of Health a couple of years ago about building a new hospital in Markdale, I think there was a great deal of skepticism, shared not only by the ministry but by a number of people even in the local community, that they couldn't possibly raise, from about 6,000 residents, over $13 million for an estimated $24-million project.

On page 25 of your remarks today you talk about 105 hospital projects that will either get started or redevelopments will occur to existing hospitals. As you know, Grey county has donated the five acres of land for the hospital. They want to present it to you as a model for rural health care and integrated health care in terms of acute care services, long-term-care services, even retirement services, and primary care services in terms of doctors' offices. We have a terrible shortage of doctors there. As a matter of fact, we have no doctors in Markdale right now. The current hospital is the only hospital between Orangeville and Owen Sound on Highway 10, one of the busiest highways in the province, I'm told. The hospital is strategically located there. In terms of a model for rural health care, I think this new integrated model we'll come up with will be very efficient and a good deal, frankly, for whatever government embraces it.

They've only got their drawings done. They would like to move to functional planning. I talked to Mr. Caplan in the last hour about the dollars that might be available, and he's willing to meet with them. The questions are: Will you meet with them again and give them some guidance, at least? If you can't commit to building the new hospital right now because of dollars, could they at least get to the next stage in the process, which I believe is drawing up functional plans?

Hon. Mr. Smitherman: The deputy may have some more information on this.

Just a couple of things come to mind. Of course, I'm pretty familiar with the Markdale community and with the state of the current hospital. We do have—and I assume it will come up over the seven and a half hours that we're going to spend together—some challenges around the integration of multi-site hospitals. This is something that the Chair is experiencing in his riding and that is being experienced in a variety of other places.

I think your focus on the last bit, on the functional plan, helps us to understand just how complex the situation is with respect to hospital capital funding, because you've introduced one of those variables. Sometimes a community is already at the point where they think they're ready for a new hospital before functional planning has even been initiated or signed off on.

The assurance that I'll give you, to answer your question, is yes, I'd be happy to meet with the hospital. I believe the deputy has had some conversation of late with the CEO of the network of hospitals that Markdale is part and parcel of and he may have some additional information to pass on.

Mr. Wilson: Thank you.

Mr. Ron Sapsford: Just a minor update from my perspective: I think initially, when this proposal was received, it was for the rebuilding of the hospital. In subsequent discussions it's clear, as you've suggested in your question, that the hospital is interested in pursuing other avenues and linking with other levels of care.

Certainly the idea, in rural parts of Ontario, of integrating multiple health services is something the ministry is actively supporting. I'll undertake, certainly, to continue to meet with the hospital or ministry staff to give them the guidance that you have suggested.

Mr. Wilson: Minister, I just want to thank you for agreeing to meet with them, and I'll send you a note to follow up on that.

The Vice-Chair: The Chair recognizes Ms. Martel.

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Ms. Martel: Minister, Deputy, political and bureaucratic staff, thanks for the work in the estimates to date and for your participation here this morning.

I would move right into questions at this time, and I want to start with nursing numbers. I've been for some time trying to track nursing numbers in the province, because I am interested in understanding where the government is at in terms of its commitment to meet the election promise to hire 8,000 new full-time nurses. I wanted to just look at some of the announcements that the government has made in this regard and then ask a series of questions.

Let me go first to some of the announcements the government has made in this regard. I'll go back a bit, to January 17, 2005. It was the same day, Minister, that you were talking about projected nursing layoffs in the order of about 757 full-time equivalents. You also said, on the same day, "As a government we are committed to protecting and promoting full-time nursing jobs, and this year alone we have created some 2,800 of them."

On May 9, during Nursing Week, you made a statement in the Legislature, and it reads as follows: "In all, last year we funded 3,052 new full-time nursing positions in our hospitals, in our long-term-care homes and in home and community care. Already, 2,402 of these have been created, with another 650 funded and in the process of being created."

The Premier earlier this summer, in July, in Windsor, talked about nurses again and said the following: "Since coming to office, 3,002 full-time nursing positions have been created in hospitals and long-term-care homes."

A little later, this fall, Mr. Fonseca put out a release on behalf of the government talking about nurses again, where he said, "We have invested in more than 3,000 new full-time nursing positions in hospitals, long-term care, home care and community mental health."

Today, in your statement, you say you're continuing "to build on the more than 3,062 full-time nursing jobs that I mentioned earlier we have created...."

The numbers, I can understand, will fluctuate, but I really want to have a clear understanding of the difference between "funded," "created" and "invested," if we can start there.

Hon. Mr. Smitherman: I think "funded" and "invested" are the same thing. What you have sometimes is a flow-through, so you make an investment in a certain sector. Let's use long-term care as the best example of this. We have invested enough resources in the long-term-care sector to get 600 additional full-time jobs for nurses. To date, based on the surveying we do, which is the mechanism by which we hold accountable, we have created 375. Those 375 form, therefore, part of a number of 3,062 created; so 3,062 created, with the full recognition of more yet to come in long-term care. If it would be helpful, I could walk through four different numbers that contribute to the 3,062 created, and I could identify those areas where additional investments made, or in the process of being made, will result in more jobs being created. Is that helpful?

Ms. Martel: I have some of those already, and I was going to raise them. But I just want to be clear, from your perspective, the "created" would mean essentially bodies in those positions right now.

Hon. Mr. Smitherman: Yes, verified.

Ms. Martel: And they are new positions.

Hon. Mr. Smitherman: Yes.

Ms. Martel: And they are full-time.

Hon. Mr. Smitherman: Well, the only caveat to that relates to 1,000 positions that will each year see a different set of new graduates being given the opportunity to experience some of the clinical-setting work they require. We will be able further to track over time a lot of those new grads who have gone into a funded position, which is for a shorter term, who have transitioned to full-time employment. That 1,000 would be the only caveat to your use of the word "full-time," but yes, all of these are new.

Just as an example, each year we make available 1,000 opportunities for new grads to experience nursing. We're not counting that each year, we're counting that one time, because each and every year there is such an opportunity. But that would be the only caveat.

Ms. Martel: Let me start with those ones, then, because I do have a concern as to the government using that number as a full-time position. It's clear in correspondence that I also have from the ministry that the government is using the 1,000 full-time temporary nursing positions in hospitals as part of the 1,000 positions that have been created. I question the government using that as a number related to a full-time position that has been created, because your ministry has also advised me that those positions may last between three and six months, that the decision to actually have those positions flow through to a full-time position is at the discretion of the employer, and that the ministry even today could not provide to either me or the public any indication about how many of those have actually been filled.

I got a letter from the nursing secretariat dated September 14 which says, "The new-graduate internship positions are temporary full-time positions for nurses that have graduated in the last 12 months. At the discretion of the employer, these positions may last between three and six months. Funding for 1,000 positions has flowed, with final reports from hospitals and long-term-care homes expected by the end of October." So at this point you don't have a breakdown of what happened to those positions, and because they are positions that may last between three and six months, they may rotate every year, but it's hard to imagine that those can be counted in the system then as 1,000 full-time jobs that will be in place and be able to add to the system.

Hon. Mr. Smitherman: You could debate this all day. I've been transparent in putting them there. The case that I make to you is, they are there every year. The conditions are as you've said. They have an ancillary benefit which you're saying we can't measure, and I agree to acknowledge that they have also caused the transition for additional nurses to be employed. So I take

your point that the 1,000 have actually created additional jobs that we're not even in a position, so far, to be able to take stock of.

Ms. Martel: Minister, if I might, I don't even think you're in a position to say that. The ministry has said to me very clearly that you expect some final reports from hospitals and long-term-care homes at the end of October, and I have requested a breakdown institution by institution of where those positions are. Even today, you couldn't say with any certainty that there are 1,000 new graduates in either three- or six-month positions in hospitals or long-term-care facilities. You don't have that information to make that claim.

Hon. Mr. Smitherman: I don't think that's accurate. I think that we do. I think that the ministry is in a position to be providing resources to fund 1,000 of these on an annualized basis. I think it's an appropriate point to be able to make to Ontarians, that there are 1,000 new positions for new grads that are made available every year that certainly weren't there before we initiated a nursing strategy. The nature of their being temporary does not negate the fact that each and every year there is in the Ontario health care system this opportunity. We're counting them in that sense.

What we've not had the chance to do so far is take advantage of the situation that I came to learn about on an anecdotal basis during a visit to Geraldton this summer, where I met a young woman who was working in the hospital there, who in fact had gained full-time employment as a result of being given the opportunity to do a stint on a temporary full-time basis after her schooling. So there are transition opportunities that are being created for these new grads that we also seek to be able to capture, and haven't so far, in the list of employment created.

In terms of your desire to have information broken down on an institution-by-institution basis, if I could use that word, we are also working very, very diligently to try and improve the data collection capacities as relates to employment around nursing. I would candidly say to you that the greatest frustration—I mentioned this before in the presence of two former health ministers. We're going to greater strides than ever before to be able to gain access to that information in a timely way and to be transparent about reporting it. I'm asking for the same level of detail to ensure, bottom line, that a dollar invested in the Ontario health care system for an express purpose is spent on that purpose, and that's part of our accountability agenda as well.

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Ms. Martel: But it is your reporting of it that leads me to raise this concern. If the ministry had in its possession now a final report from hospitals and long-term-care homes that clearly showed that not only had funding for the 1,000 positions flowed, but in fact in those hospitals that received money and in those long-term-care homes that got money there were actual new graduates in those positions and you could verify that, then I could say with some certainty that it looks like those 1,000 positions have been filled—created.

We're going to argue about whether those are full-time or not, because I don't think the ministry should be using that number in that sense, but the ministry can't provide me with that information now. You use the 1,000 figure as positions where there are bodies in them and you don't even have the information from either the homes or the hospitals to prove that.

Hon. Mr. Smitherman: To the contrary: What I have in my possession and what I have knowledge of is that across the breadth of the long-term-care sector and the hospital sector where these opportunities would be provided, there are requests, from those very same institutions that you ask about, for funding for more than 1,000 of these grads.

If you want to wait for the time lag that is necessary in the data collection as relates to nursing, OK, then we can pick up this debate in two or three years, because the system that we've had around timely access to data on nursing means that those lags are there. We don't even have a combined data collection capacity. We have some at the college. RNAO does their own bit as well. So we're involved in a more intensive level of surveying, which is an important part of the accountability, and that's never been there before.

Here's what I know for sure: There are 1,000 new positions available this year for new grads to experience the incredibly important work of front-line clinical care. We have this year, from those institutions where the opportunities would be provided, requests for funding for more than 1,000 of those positions.

I have all the assurance I need and all the assurance that is required to tell Ontarians that there are, since our government came to office, 1,000 annual opportunities for new grads to do front-line clinical care work that did not exist prior to our coming to office. I think that's a satisfactory circumstance for Ontarians.

There's further evidence that giving those new grads that opportunity is bridging them, giving them the opportunity to transition to full-time employment. I acknowledge candidly that we have more work to do to determine just how many have gone, and in what circumstance. That will be the next step as we seek to improve our capacity to collect good, quality nursing data.

Ms. Martel: Because you don't have that now, and we're hoping that is happening.

Hon. Mr. Smitherman: We have a lot more of it now than we did two years ago, but we have a lot more distance to travel on that.

Ms. Martel: But you don't have numbers now that would show, after a three- or a six-month temporary stint in a hospital, how many of those nurses are actually being hired. You don't have that.

Hon. Mr. Smitherman: But a moment ago you were arguing that we can't even prove that 1,000 spots are being used—

Ms. Martel: That's right.

Hon. Mr. Smitherman: And now you've reversed—

Ms. Martel: No, because your ministry has also told me I can't get—

Hon. Mr. Smitherman: Now you've reversed arguments.

Ms. Martel: No, that's not true. Your ministry has told me that you don't have the data to prove that there are 1,000 positions and 1,000 bodies in those positions. You have certainly said that the money has flowed, but to say that those positions have been created, that there is an actual nurse in that position, is false. Your ministry has told me you don't have that information and that I can't expect it until the end of October.

Hon. Mr. Smitherman: No. There's got to be some distance between your desire to have some audited confirmation of numbers and some common sense application for you to be able to use a word like "false." This is a stretch; this is a considerable stretch.

What I know for sure is that I've got 1,000 positions available this year for hospitals and long-term-care homes to be able to provide nursing assignments on a full-time basis for new grads that we didn't have when we came to office, and I have demands for more than 1,000. In a similar—

Ms. Martel: Let me just interrupt you there, because you say this is a stretch. Let me give you an example of why I raise this. In a separate FOI request—and you'll have these numbers in front of you in terms of how many new nursing positions have been created in hospitals over $100 million and in hospitals under $100 million—the ministry is using a figure of 1,202 full-time nursing positions in hospitals, verified through hospital nursing plans submitted to the ministry.

Three examples: In the information you gave me, you said that Bluewater Health has created 11 new full-time nursing positions—or Bluewater Health told you that. Central East: Lakeridge Health Corp. told the ministry that nine new positions were created. The third one I want to raise is the Sault Area Hospital, which said that 20 new positions were created.

At the same time as you were using those figures to show that some 1,200 positions have been created in hospitals over $100 million and under $100 million, we also know that at Lakeridge there has been an announcement of layoffs of 39 full-time RNs and 57 regular part-time RNs; that in the Sault Area Hospital there has been an announcement of a layoff of 25 full-time RNs and 10 regular part-time RNs; and that at Bluewater, you're looking at a layoff of 28 full-time nursing equivalents.

I raise it in this context: Your ministry provided me with information that I'm sure at the time was correct to show how many new nursing positions have been created. After that point in time, layoffs of RNs have been announced. Those are just three examples; I'm sure there are more.

How can you, in the face of my just raising those few examples, say with any kind of certainty that there are 1,202 new nurses working in full-time positions in these hospitals when we know in fact that layoffs of those same nurses are going on?

Hon. Mr. Smitherman: Now you're saying "going on," and the three times prior to that you said "announced." Between those two things is the dilemma you've created for yourself, which is that in a certain sense you've now relied upon a press release to try and create, as real, a circumstance. You said "announced layoffs." Take a look at the history of the way hospitals communicate around nursing layoffs. Go and talk to ONA about this, or read this report out of Peterborough. It has Diane Crough of the Canadian Union of Public Employees. The headline says, "No Job Loss in Hospital Layoffs: Union Says Cuts Just a 'Make-Work Paper Project.'" This happens all the time, where a hospital, as a part of I think sometimes its desire to get some attention to its circumstances, projects a nursing layoff which may, or in many, many, cases does not, hold true. A moment ago you were asking me hard questions about verifiable information, and then you chose to work off a press release and the word "announced" to try and prove your point. I don't think it does.

Ms. Martel: Minister, if I might—

Hon. Mr. Smitherman: Sorry; I'm not done.

Ms. Martel: Let me give you this press release. This is what you said on January 17, 2005: "In addition to the estimated 1,145 administrative full-time equivalents, or FTEs, that will be eliminated, it is projected that up to 757 nursing FTEs will be eliminated, as well as 453 non-nurse clinical FTEs." That wasn't an ONA press release; that was your statement. You may look at ONA and try to say that maybe those numbers aren't true; that's what you've said about full-time nursing equivalents. How do you know that the layoff possibilities in Sault Ste. Marie and in Lakeridge that I just outlined are not part of the 757 nursing full-time equivalents that you announced were a potential to be lost?

Hon. Mr. Smitherman: The point is that you're now using the words "projected" and "possibility." The point of the matter is that we don't know. There are always going to be lags, of course. There are tens and tens of thousands of nurses who are employed across the breadth of the hospital sector. There are a number of hospitals in Ontario that are taking some effort to address their budgetary deficits. There are a variety of other hospitals in Ontario that are constantly increasing employment because their circumstances are better. The point is that none of us knows. We all know only at the point that our ability to extract better-quality information in a timely way is advanced.

What you've decided to do is to use press releases and words like "projected" and "possibility" to create a circumstance where, yes, I must acknowledge that across the Ontario health care system there are sometimes reductions in employment in hospitals, but this often happens while at the very same time employment is being increased in other places.

As the information becomes available, we can update the numbers we have, but it's appropriate to be able to build on the quality data that we have, and that's what backs up the numbers that we're offering today. Yes, it's an evolving situation; no one would disagree. When we get to come back for estimates next year, we'll have an

opportunity to have a discussion with a broader array of information to look at the pattern that actually transpired. But until then, I think it's very, very challenging to know.

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Ms. Martel: But that was the number that you used in January, and now we are in September.

Hon. Mr. Smitherman: I used the word "projected."

Ms. Martel: Can you tell us what the projected layoff is now across the hospital sector? You used that number with some confidence, I assume, in January. What would it be at this time?

Hon. Mr. Smitherman: I have no update on that number and I have come in contact with next to no information about numbers of nursing layoffs even approaching what was projected at that time. Furthermore, I've been working very closely with ONA, RNAO and RPNAO on programs that would make possible a bridging around nursing employment disruption. That's the kind of work that's ongoing, so I have nothing that can validate that 757 number, but I acknowledge it was one that's in the public domain.

It really does make the point that we want to have a discussion here in the absence of good-quality, hard data. I've said already twice or maybe three times that one of the greatest frustrations, and one of the things that Dr. Tepper is focusing on as he comes into his new role, is our capacity to be able to operate more strategically as a Ministry of Health based on access to more timely data. At the moment, all of this stuff flows through from a variety of reports and is very, very rarely available in a timely fashion, making it more difficult than any of us might prefer to access this information.

Again, it helps to make the point about the necessity of the Ontario Health Quality Council, because in Ontario today, on the nursing file, you do not have one-stop shopping in terms of where all the information is collected and verified. You have some with the college; you have some with RNAO based on surveying; you have surveying being done from the ministry. What we seek to create for the benefit of everybody, so there's much greater clarity around these questions, is getting all that information in one place and having it digestible and verifiable with some independence associated with it. This is what we're working toward.

Ms. Martel: Let me back up, because the announcement that you made was related to fiscal year 2004-05, not this fiscal year, the projection of the 757. So that was in a past period. I'd like to ask you again if the ministry has not, for a past period where you made an announcement of potential nursing losses, done any other work to determine exactly what the layoffs were for that past period.

Hon. Mr. Smitherman: I'll repeat what I said and then maybe the deputy can give you some better insight into the flow around information from hospitals and how timely or not that is. But the point I will make to you again is the point I made before: In the winter, we made an announcement which acknowledged that there was some work to be done in some hospital environments to reduce workforce in the fashion of being able to get those hospitals in balance. Associated with that, there was a number put out there. As I've said to you already, I have no evidence—none has come forward to me, anecdotally or through summary in some other way—that indicates that that number proved to be a reliable number.

You're asking me, for the 2004-05 fiscal year, the fiscal year ending March 31, with projections of nursing layoffs of 757 associated with that, how many occurred, and I can tell you that I'm not aware of any.

Ms. Martel: I'm hoping that the deputy can provide us with some additional information.

Minister, you felt confident enough to make an announcement about those kinds of potential layoffs. I find it hard to imagine that nine months after, the ministry wouldn't have a clear indication now of what actually happened. Nobody else made this announcement; you did.

Hon. Mr. Smitherman: It makes a point that I made earlier rather well, which is that it has become a long-standing practice in Ontario for hospitals to exaggerate nursing layoffs with a view toward creating emotion and turmoil around that. I think that number may in fact reflect what was going on at that time, but perhaps the deputy could—

Ms. Martel: But if I might, Minister, it's not a number that was put out by the OHA; it was in a statement that you made. I was at the press conference here at Queen's Park the day you made it. So we're not talking about hysterics on the part of the OHA or ONA or anybody else floating a number out there. This was the number that you used in relationship to a process that occurred around December 24, where you told hospitals they could go ahead with their plans, which included these kinds of projected layoffs. If you went ahead and you publicly used this number, then you must have had some confidence about it. It wasn't anybody else who used that number. It was you.

Hon. Mr. Smitherman: I totally agree, but it was a number that came forward from Ontario hospitals, and there's a really, really, really well-established pattern where projected layoffs don't occur. Go back to that—

Ms. Martel: Wait a minute, Minister. It was a number based on the plans that they had submitted to hospitals about what they had to do to balance their budgets.

Hon. Mr. Smitherman: And as they move forward with their plans, as they are accountable and community-board-governed, some of it takes shape in the way they projected, and some not.

Go back to this press release coming out of Peterborough, with a voice from the Canadian Union of Public Employees. We have a circumstance in Ontario where if you move a nurse from one part of a hospital to another, to a different kind of assignment, that can be captured as a layoff. Those are some of the things that were rolled up in those numbers, based on information that hospitals were providing.

There's probably a lag time of about a year before one can know exactly what the implication was on the front

line in Ontario hospitals, but I can tell you pointedly that in terms of the projection, the number that was used, a projected number, I have not seen very much evidence that those have transpired. Some may yet transpire.

Maybe the deputy on process, if there's something helpful.

Mr. Sapsford: You're having a discussion about what, from my point of view, is a very, very difficult area to be precise about in terms of numbers, partly because when we talk about these issues, are we talking about positions or are we talking about bodies, and how do we measure these questions? Every time a question is asked about nursing staffing levels, they are asking the question from a slightly different level. Quite honestly, the ministry struggles to answer these kinds of questions with precision, partly because each part of the health care system currently gathers this information from a different base. Hospitals report these numbers one way; long-term-care homes report them a different way. Some parts of our health care system don't report them at all.

In the case of hospitals, we have extensive information about full-time equivalents, which is really based on the total number of hours, but that's problematic because it doesn't reflect accurately what might be going on with respect to overtime work or additional staff. So I think what the minister has tried to say and I would reinforce is that the ministry is looking at how we gather this kind of information consistently across the health care system so that the ministry is in a position to provide a better set of answers to these very difficult questions. Part of that is definitional, part of it is gathering the information through improvements to our information systems, and part of it is improving the timeliness of the data, because in some cases this information is only recorded yearly; in other cases, we have to do special surveys to collect it more frequently.

Ms. Martel: If I might, Deputy, the minister announced it in the context of 757 nursing full-time equivalents, which I assume would have come from information that was submitted by hospitals, that they submitted their projected layoffs in terms of full-time equivalents. It was other organizations, like RNAO, for example, who said that would mean more bodies because of casual and part-time work.

So if the ministry has some indication or some evidence—because the minister has said he hasn't heard that much in the way of layoffs. It would be helpful if you could give to the committee that information in the same way that it was phrased to the public, which was in terms of 757 full-time equivalents. What was the end result for the end of fiscal 2004-05?

Mr. Sapsford: I can't speak to that specifically in terms of the answer to that specific question. I can give you my sense of what would have happened in the circumstance. I can't speak to the 757 number specifically, but that would have been an estimate of positions or full-time equivalents, as you've suggested. Over the course of the operating year, hospitals would work to minimize that. So from that point of time, presumably based on estimates of what hospitals would have to do, those plans would change. The difference between the numbers of positions and the numbers of actual people involved are two very different questions, with the ministry having ability to talk about equivalents and less ability to talk about people.

The Vice-Chair: Thank you, Deputy, and thank you, Ms. Martel.

The committee will stand recessed for half an hour. When we return, the minister will have one half-hour to reply and to make concluding comments.

The committee recessed from 1200 to 1234.

The Vice-Chair: The estimates committee will come to order and reconvene for the Ministry of Health. Minister, you have 30 minutes to respond to the opening statements of the opposition parties.

Hon. Mr. Smitherman: Mr. Chair, I always believe it's good training for when the House returns to spend more time on the cut and thrust. I believe that if I waive my time so that we are in rotation, we could just pick it up.

The Vice-Chair: Yes.

Hon. Mr. Smitherman: Then I think I'd like to waive my half hour and just proceed to the rotation.

The Vice-Chair: If I could ask Ms. Martel to take the chair, I'll take the opposition's 20-minute rotation.

The Acting Chair (Ms. Shelley Martel): Mr. O'Toole, you may begin.

Mr. John O'Toole (Durham): Thank you, Minister, for your presentation this morning. It's my privilege to represent the riding of Durham, and you mentioned on a couple of occasions some ongoing concerns that we have. I also appreciate the complex challenges, as described in the exchange between you and Ms. Martel this morning on the Ontario nursing association strategy on the 8,000 nursing positions, and how difficult it is to pin down the numbers.

But I do have a duty and a responsibility to represent the needs of the Lakeridge Health Corp., along with other hospitals in the province—its uniqueness as a multi-site facility that is also struggling with a redevelopment issue at the Oshawa site. You probably know that the annual general meeting of the Lakeridge Health board was held this past June, I believe, in Clarington, my community. At that meeting there were several key questions asked. I wasn't really part of the meeting, except that out of respect for the board and the work they do, I was in attendance. They made the points of a multi-site facility underfunded on a per capita basis because of the traditional funding under the global budget model, and the JPPC process of how they reinvent that basic model of funding for hospitals on a site or on a corporate basis.

We went through the consolidation of hospitals from what was, I think, five hospitals in Durham prior to the Health Services Restructuring Commission and the ultimate formation of Lakeridge Health Corp. The Port Perry hospital, which was in Scugog township, was a very efficiently run, very widely supported facility within the Scugog community. It had undergone an expansion in

the time of Frances Lankin and the NDP but really never received operational funding to get it up and going.

As a compliment to them, they were basically a model hospital. In fact, when Jim Wilson was the minister and also when I was parliamentary assistant in health, I worked with Dr. Ruth Wilson and we looked at the family health network and how it would fit at the Port Perry community facility. All the hospitals there work collaboratively already. The doctors work collaboratively with the pharmacist, and the lab work is right across the road. They do 24/7 coverage at the hospital. The hospital foundation is very progressive and able to raise some capital dollars when and where needed. It's really quite a unique site. It serves a rural practice. Dr. Bill Cahoon was chief of staff. I think John Stewart is the head of medical staff there now. He is very widely respected for his work on resistance to antibiotics. The ministry has funded some of those things. They're having a struggle with identity under the Lakeridge Health corporate model.

They do provide some unique services to the community. I know that you have or probably will meet with Mayor Marilyn Pearce, who has been spearheading a community drive to find in the governance model—much like Women's College Hospital—some unique and separate identity under the corporate organization. I don't know whether I'm describing all this correctly; I hope I am. But I would be supportive of that unique community, because it does serve a very broad catchment area: part of Brock township as well as perhaps Victoria county, or now the city of Kawartha Lakes. Its catchment area is separated geographically by what many people refer to locally as the Ridges. People essentially don't travel in a north-south direction; they tend to travel more east-west and a little bit north. So their hinterland and catchment area is somewhat different than is assumed by the model.

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But if you look at Lakeridge Health and Rouge Valley, the two systems service Durham. Then I look at the LHIN that's coming in, and it services Victoria-Haliburton and Peterborough. In some arguments, in some ministries, we're referred to as the GTA, and in other ministries, we're east-central, in community mental health and other kinds of funding. In the LHINs, we're funded as east-central. It is a problem for them and becoming much more problematic in the governance model.

Minister, are you prepared to meet with those supporters of the Port Perry community hospital and to find a resolution for their coexistence in Lakeridge or some other solution to their governance and funding issue? Ultimately, they see the level and number of services being reduced to support—the current deficit is in the $20-million range for Lakeridge Health. That's problematic under Bill 8.

I've thrown a lot on the table, but I know you're well familiar with it, and I'd appreciate a concise response, if I could.

Hon. Mr. Smitherman: A concise response to a rambling question.

Mr. O'Toole: It's background, George.

Hon. Mr. Smitherman: Well, there's a lot there. Let me try and take a stab at it. Firstly, I think it's important to note that since our government has come to office, we've invested more than $23 million in additional operating resources at Lakeridge Health. You did allude in your question to some of the challenges around capital. Going back to a report in 2002, your government initiated, and we've certainly followed suit, an initiative to address a lot of the concerns that were in place around that missing capital piece and the regional cancer centre at Lakeridge, which we've been very, very supportive of.

Firstly, to the issue of a meeting with the mayor of Port Perry: I've met with her and spoken with her on this subject many times. She's of course somebody that I know very well. I've actually been encouraging her to work with other municipal leaders, and I believe she's been in contact, therefore, with the mayor of Halton Hills and the mayor of Picton, with a view toward taking a look, because they, as communities served by the smaller hospital in a multi-site hospital configuration, have some of the same concerns.

I want to introduce a few words. I have already initiated a process with the JPPC. This is a body that shares a lot of responsibility for health services planning and funding between the ministry and representatives of the Ontario Hospital Association. I have put this multi-site funding issue on their agenda, and I've done that at the instigation of Mayor Pearce particularly.

What we need to get to is a point of defining core services. I think this is where the protection comes for communities as it relates to these multi-site hospitals. Part of the fear is that in an environment—I'm not one of those who believes that every change should be characterized as a cut. As an example, a decision to concentrate the provision of service at one hospital in a multi-site environment is not necessarily a bad thing, and very often, from a clinical standpoint, it's a good thing for health care. In an era when you want to use new technology—let's say you're doing cataract surgery at all the sites of Lakeridge and there's a new piece of technology which will enable an advance in that surgery. It's obviously not that sensible, if you're going to use the word "system," that every service would be delivered around the corner, because that's going to make it less likely that you can adapt technology. We also know that the clinical outcomes are proven to be better in places where they do more of the service. These things are compelling arguments in favour of some logical consolidation of service. The challenge, therefore, becomes for each hospital to have a celebrated mission, maybe not exactly the mission they've always had, but a celebrated mission nonetheless. I think that helping to define core services is part and parcel of that.

I would commit to the member that, yes, I'm very aware of this. I know there's a real angst there. I will very happily meet with the mayor, but I will continue to press the JPPC to pop up some resolution to this, because this is not a situation that is unique to the situation at Lakeridge.

Just one last point, if I could. In the LHIN context, I think one thing that is important to keep in mind is that we believe fundamentally that the best health care services should be available as close to home as possible, and we're building up our community-based services. But when you get into the provision of services like regional cancer services and cardiac—the higher-end stuff—there is always going to be some concentration of that service in a smaller number of places. People should look at the LHIN in that context. We need to have the capacity for closer-to-home, maybe what I would call district planning, while still recognizing that some services, higher-end services, are much more likely to be provided on a regional basis. But I'm happy to work with the member on trying to address that.

Mr. O'Toole: Yes, I appreciate that response, and I'll try to be a little bit more succinct. I respect the fact that you have a good background on the local area and how some of the multi-site—and constraints under necessary balanced budgets are going to have over the next while, as was alluded to by Ms. Martel in her remarks on the layoffs.

I do want to put on the record one outstanding question that has been on record with you: a letter from me to you on June 24, 2005, asking for a copy of the Davidson report. This is a media issue. It's a report on the capital program at Lakeridge that you alluded to in your answer. You and ministry officials have been cited in two recent articles in the paper. Some of the people behind this question being asked at the AGM are influential—I don't necessarily mean in a political sense; they are people who have great insights and have made community contributions.

I think it would be a good way of levelling the field and clarifying—even though that report was filed when Tony Clement was minister, I have not seen it. I know the report was done on the capital program at Lakeridge Health, Oshawa, and it was something to do with maybe spending money ahead of approvals. But I think that's behind us. I think it would clear the water for you; it may be helpful. I'm not trying to be disruptive here, I just think I owe it to my constituents to put classically on the record the request for the Davidson report. I'll probably be interviewed on that this afternoon—not to be smart, but I was called this morning on it. People in Ontario do watch these proceedings.

Hon. Mr. Smitherman: That's why I got my hair cut.

Mr. O'Toole: The second issue—quite a different issue—is long-term care. I think both governments probably wear some of the problem there. Because of the angst in capital projects and fundraising, as Ms. Witmer outlined this morning, work has been done and the community expectation level is way out of sync with actual ability to deliver on time, on budget: That's a whole different deal.

The second issue that I want to put on the record is the ongoing series of communications from me to your ministry starting in April, again in May, June, July and others, and I've had modest, if any, response. That's on the Community Nursing Home in Port Perry, a facility that had their case mix index downgraded, resulting in some announced layoffs. Whether or not they've actually taken place, I can't comment on.

Ms. Martel was the first to raise this question in the Legislature with you some time in April. In fact, I at that time had met with the staff at the Community Nursing Home in Port Perry and it was brought to my attention. I had asked for a review of the case mix index, which results in increased or decreased flow of operating dollars. So can you respond to the letter from April 21, May 3 and July 26—and I'll make you a reference to the Ministry of Health log numbers: 20501048. I look forward to passing that on to persons that I represent in the riding of Durham.

Hon. Mr. Smitherman: Sure. I'll be as succinct as I can on this. Two points: Firstly, I noticed towards the end of your very nice question about Lakeridge Health that you sought to try and assess—you said, "This is something that I think both governments have some responsibility around." I just want to say, in acknowledging our willingness to release the Janet Davidson report and in keeping with my desire this morning for appropriate accountability, I'm not at the point where I'm fessing up to challenges that were created in the run-up to the work on this report in 2002. But I will acknowledge—

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Mr. O'Toole: To balance it, I just want to put on the record—I do acknowledge that—that I pointed out to Minister Caplan this morning that it was his mother who made the first announcement at Lakeridge Health in 1989, when I was a regional councillor. All governments of all stripes, including Ms. Lankin, when she was minister—I sat on the same stage when the other announcement was made. So I'm happy to be here and share this with you and all of the other persons of all parties.

Hon. Mr. Smitherman: I'm looking forward to those days coming pretty early in 2006 and mid-2006 when the emergency, surgery and critical care expansions will be complete and when the regional cancer centre is complete. So I can say to the honourable member, I have no apprehension whatsoever in releasing that report. If that's helpful to the local community, we will very happily do that.

I want to just say a word of apology. We have a lot of work to do to do a better job of responding to correspondence. It does have a bit to do with volume. Health questions sometimes are more complex. This is an explanation, but not an excuse. If you are in a circumstance where you're awaiting a response to a letter, I just encourage you to call my caucus liaison guy, Scott Lovell, and we'll make sure we do that for you.

The case mix index is a pretty important aspect of the way our long-term-care-home system works, because not all residents in long-term care—approximately 75,000 of them—have the same level of acuity. What we want to do—and you would know this stuff very well, from your time at the ministry—is keep an incentive in the system that appropriately acknowledges that if you are caring for

people with a higher acuity and therefore more need, there's more funding made available; in other words, that we've got targeted funding which reflects the state of acuity of patients. This has been developed with the long-term sector over a period of time. That's the case in Port Perry. If Port Perry changes its case mix index over a period of time so that they're caring for people who have a lower acuity, as in the case, then they are going to have fewer resources to be able to address that. But they would still have been the beneficiaries of investments that came across the breadth of the long-term-care sector, which, as I understand in the Port Perry instance, did help to mitigate somewhat against risks related to layoffs. We'll be happy to get you that report.

Mrs. Witmer: One question: This morning you talked about LHIN legislation being introduced. Do you guarantee that the enabling legislation for the LHINs will indeed be introduced during the fall session of 2005?

Hon. Mr. Smitherman: Yes.

Mrs. Witmer: Is it your plan that it would be passed before the House adjourns at the end of 2005?

Hon. Mr. Smitherman: I think it's dangerous territory to presume how a Legislature will deal with a piece of legislation, but it will come forward as a piece of legislation that enjoys a strong degree of commitment from my government.

Mrs. Witmer: I guess I'm wondering; all of the LHIN deadlines have not been met up until this time. You are absolutely guaranteeing that the legislation will be introduced and, if at all possible, passed? Is that what I hear you saying?

Hon. Mr. Smitherman: I hear you paraphrasing. I'm very happy to repeat the answers I gave, which when you read them back, will be very clear. We're going to introduce the piece of legislation. I recommend it to members of the Legislature. Of course, it's a significant piece of legislation and appropriately will have to have some debate, but our government will make it a priority to pass it. On the issue of—well, I'll leave the other matter for perhaps a later question.

Mrs. Witmer: Given that there is no legislation at the present time, could you tell us what the LHIN staff are currently doing?

Hon. Mr. Smitherman: The LHIN staff at the moment are limited to chief executive officers. They, along with board members—the first three have been appointed—have been doing what I think is the most essential piece of business for local health integration networks: beginning to create the dynamic for a new conversation about the way we make decisions around planning, funding and integration of health care services in Ontario. They're out there building relationships at the community level which we believe are going to pay dividends as we move forward. Offices are in the midst of being opened and more recruiting is ongoing for positions. The rollout continues apace. I would have to say that based on the feedback I get from providers, who say, "Thank you very much, once and for all, in our province for providing us with a vehicle whereby health providers all operating in the same geographic area are actually not just incented, but encouraged to come together and look for opportunities to better work together," that we are on to something in terms of creating a new culture and a much better dynamic for the coordination of health care, all of this with the patient at the centre of that planning.

The Vice-Chair: Thank you very much, Minister. The Chair recognizes Ms. Martel.

Ms. Martel: I actually want to go back to some nursing numbers, but I do want to follow up on the Port Perry issue, because it's a concern for me now not just in Port Perry but in two other homes with a similar circumstance. The issue in Port Perry was that the CMI decreased, but at the same time as that happened, the home got more money. My understanding is that as part of the service agreement with every home that received additional funding last year, the agreement was that you had to hire staff, not fire staff. There is no change in the resident population. There is a change in the CMI, but the service agreement doesn't make any reference to a change in the CMI. So the service agreement that currently is in place would say that as a result of getting new funding from the government to add to base, this home should be hiring, not firing, staff. That is an issue not just in Port Perry but in two other homes now as well where owner reps have brought that to our attention.

Hon. Mr. Smitherman: Pardon me for saying it so bluntly: It's pretty easy to muddle that up the way you have, but it's also pretty easy to understand how these are two separate things.

All homes across the province of Ontario received additional funding. We are on track to create more than 2,000 additional work places, full-time equivalents, in those organizations, including at least 600 nurses. Port Perry and every other home is part and parcel of that, has associated with it additional funding.

At the same time, Port Perry and some other homes, as is the case on a case-by-case basis, have had a reduction in their CMI that has another number, an offset. These two taken together mean that the additional resources we were putting in across the breadth of the long-term-care sector have resulted in mitigation; in other words, reducing the number of people who would have been lost in that home simply on the basis of the calculation of CMI.

Ms. Martel: But the service agreement makes no reference to CMI, as I understand it, no reference at all in terms of what the obligation is with respect to the home as the new money flows in. The obligation on the home as the new money flows in as per the service agreement is to increase staff.

Hon. Mr. Smitherman: That's nice, but it doesn't negate the fact that there's also an application of a formula called CMI which takes place. These two things taken together create a net result, and the net result is that there were fewer people reduced in the Port Perry home because of the CMI as a result of the fact that we were at the same time putting in additional resources. These two things net out, and it's not so hard to understand how.

Ms. Martel: So it would be your view that the home is not in violation of the service agreement when it has layoffs?

Hon. Mr. Smitherman: Yes, of course. The home has layoffs as a result of a reduction in their CMI. Those layoffs were reduced because we were making investments in the long-term-care home at that point, so our investment mitigated the full impact from the CMI reduction. But no, I wouldn't think they were in violation. It would seem quite logical to me how that would transpire.

Ms. Martel: And that would be the case both with respect to Port Perry and any other home where staff are being laid off, even with a new investment, because of a reduction in CMI? You would argue that in those cases the service agreement is not being violated?

Hon. Mr. Smitherman: There are 600 long-term-care homes in the province. The Port Perry one, as it's a matter that you've brought forward before in the Legislature, is one where I enjoy a bit more knowledge and I know that the investment that we made mitigated the overall layoff.

I'm not too keen to answer a question without detail, but if you want to bring the instances of those other ones forward, I'm happy to go back and take a look at them so that I can give myself the assurance that nothing there is inconsistent with my explanation as relates to Port Perry.

Ms. Martel: I think the difference is in our understanding of what the service agreement says. In the two other cases, it would be the same scenario, as I understand it, with no change in the resident population, but a change in acuity, a decrease. So at the same time as new money is coming in for nursing services and other health care services, the home is still laying off people because of the change in acuity. But the service agreement is very clear. The owner-operator signed on to get new money on the basis that they would hire new people, not have layoffs.

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Hon. Mr. Smitherman: Firstly, you've said twice, or perhaps three times, that the population was the same. You may be talking about the quantity, but I think one should be very, very careful not to lead people to think that over the course of a year there aren't changes in the population within a long-term-care home. Of course there are, and that's why we calculate a CMI. It has with it a certain expectation that if you're dealing with a higher acuity of patients, we would provide a higher degree of resource. If your CMI changes, there will be an impact from that. If you wish to separate these two things out, then what you're really asking for is that we should have applied the CMI, we should have forced these long-term-care homes to apply the CMI, to actually operate in a silo, and exit a proportionate number of people from providing care there, and then the next day open up another file-folder silo and do the hiring. The net effect is the same, but the manner in which we have worked with long-term-care homes is more beneficial because it provided greater continuity of employment and therefore greater continuity of care for residents. But it nets out as exactly the same.

I'm not sure what further I can do to explain this, but if the deputy can assist you with your understanding further—

Ms. Martel: If I might respond: On the contrary, Minister, if you wanted to have homes take acuity into account, then the ministry should have put that into the service agreement. If you had a concern that the possibility existed that despite getting new investment, which all homes did, some homes would still find themselves in the position of actually laying off staff because of a decrease in acuity, then your service agreement should have reflected that possibility, and it doesn't.

Hon. Mr. Smitherman: The possibility of adjustments as a result of the CMI is nothing new. It's ongoing and well understood. That we made additional resource available to each and every long-term-care home is very much a separate issue. They net out the same. But I think you've locked into some kind of a siloed analysis of this circumstance.

Ms. Martel: No, I don't think so. I see it very clearly. The service agreement, as it stands with every home, says that as a result of getting new money, the obligation on the operator is to hire new staff. I assume that part of the criteria also is that if they don't hire new staff, they get the money clawed back.

Hon. Mr. Smitherman: The home in Port Perry can therefore, accordingly, in keeping with the service agreement, demonstrate what the implication has been on staffing as a result of our new investment in the service agreement. All I seek to do, for the purposes of operating a system in a common sense way, is that instead of operating these two things as two separate mathematical calculations, with an impact on individuals, on employees, they blend these things together. But it doesn't separate out, it doesn't change the net result, and it certainly doesn't allow a home like the one in Port Perry to escape the accountability associated with the additional investment that was made possible by our government. Port Perry is in a position to be able to demonstrate that.

Ms. Martel: But in terms of accountability, if your reference point is, what does the service agreement say and is the owner-operator living up to the terms and conditions of the service agreement, under your definition of accountability, you'd have to say that they're in violation. They got money, and they ended up laying off staff. If you had wanted to take into account the possibility that the CMI might affect new staff coming in, that should have been written into the service agreement as a potential, for those homes whose CMI declined or decreased, even if they got new funding, might find themselves in the unenviable position of still having to lay off staff as a consequence.

Hon. Mr. Smitherman: It should come, and I think would come to those who are operating within the long-term-care sector, as no surprise whatsoever that we didn't make some announcement that we were abandoning CMI, that we were removing the incentive to acknowledge that where people have a higher acuity, we make more resources available; that's not what we did. If you

want us to amend a service agreement so that there is an asterisk that acknowledges that the application of CMI is still part and parcel of the way we're funding long-term-care homes, we're happy to look at language to do that. But I haven't met anybody in the sector who has been confronted with the same level of confusion on this point that you seem to be experiencing. They net out the same.

Ms. Martel: That's interesting, because I understand the ONA is taking this to arbitration. So it's not just me who has some concerns. They're taking it to arbitration on the basis of whether or not this service agreement has been violated.

Hon. Mr. Smitherman: Well, we'll look forward to those results.

Ms. Martel: We will.

Let me go back to some questions on new-graduate nursing money. I'd like to find out the amount of money that has been allocated for this initiative, because I've got a couple of press releases and I'm not clear on the distinction between the two: a June 3, 2004, press release that said the government was investing $50 million to create new full-time opportunities for new nursing graduates in hospitals and support experienced nurses to mentor them for up to a year, and a second release, dated December 8, 2004, that again referenced the nursing strategy but said $17.7 million for new-graduate nursing positions in hospitals or long-term-care homes and $1.4 million to create mentoring relationships. Can I get some clarification on how much was actually set aside for this initiative in fiscal 2004-05?

Hon. Mr. Smitherman: Sure. I think the deputy has those numbers.

Mr. Sapsford: For the new-graduate strategy, $30 million in 2004-05, and $10 million in 2005-06; for the late-career initiative for nurses, $5 million in 2004-05, and $25 million in 2005-06.

Ms. Martel: So the new-graduate strategy was given $30 million in 2004-05, and this year you're targeting $10 million?

Mr. Sapsford: Correct.

Ms. Martel: The late-career nursing initiative was given $5 million in 2004-05; is that correct?

Mr. Sapsford: Late-career, $5 million.

Ms. Martel: In 2004-05?

Mr. Sapsford: Yes.

Ms. Martel: And the projection for 2005-06?

Mr. Sapsford: Twenty-five million dollars.

Ms. Martel: Of the $30 million that was set aside, was it all allocated?

Mr. Sapsford: Yes, it would have been allocated.

Ms. Martel: And it is those numbers that we are waiting for, which we are to receive by the end of October, to determine how that money was spent?

Mr. Sapsford: Yes, I think the end of the second quarter was the time frame.

Ms. Martel: OK. In terms of the late-career funding that was also allocated in 2004-05, was all of that allocated as well?

Mr. Sapsford: I believe yes.

Ms. Martel: What is your mechanism for verification through the hospital sector for both of those? Is there a sign-off by ONA staff? How are you verifying those numbers and how the money was used?

Mr. Sapsford: Usually, when the money is allocated and the cash is flowed to the hospital, there is a requirement for reporting back to ensure that it was allocated or used for that purpose in the institution, so we would be expecting some kind of return information.

Ms. Martel: Are you expecting that not only for the new-graduate money but for the other money with respect to career nurses or preceptorships, mentorships etc.?

Mr. Sapsford: Yes. That's the usual process for these kinds of allocations.

Ms. Martel: OK. Do you intend to make that information public, in terms of what institutions benefited and by how much? Is that something the ministry has dealt with?

Mr. Sapsford: There's no reason it couldn't.

Ms. Martel: OK. I'd like to ask about the CCAC positions that the ministry has given me. Again, these are new nursing positions. After August 19, I received a letter from the ministry with respect to how many new nurses have been hired in the community sector. I was looking specifically for CCACs, and the information I received was 485 full-time equivalents as of January 31, 2005. What I'd like to be very clear about is that these are new positions in addition to the positions that were already there; it is not a reflection of nurses being hired by one agency as a result of another agency losing a competition.

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Hon. Mr. Smitherman: It's a net-new snapshot in time versus a snapshot in time. It's a surveying methodology, but it's a net-new snapshot in time versus a snapshot in time. It's one of those areas where we anticipate ongoing progress, because we've made many investments subsequent to that number and also anticipate making additional investments in home care. This is obviously one of those areas where the community sector is increasingly a source of employment for nurses.

Ms. Martel: I have asked for a breakdown, not just by CCACs, which have been provided to me, but a breakdown of the provider agencies that receive the funding. I've been told that the ministry's accountability agreement is with the CCACs. I'm not asking for the financial details of the contract. I'd be interested in what agency was doing the hiring and how many positions were hired per agency. To date, I've been told that because the accountability agreement exists only with the CCACs, that's not information that is available.

Hon. Mr. Smitherman: The CCACs are the ones that are responsible for contracting service providers locally and therefore are the ones who are responsible for the management of those relationships. So we get aggregated data.

Ms. Martel: How do you verify the hiring that went on, then?

Hon. Mr. Smitherman: The CCACs verify the data about the hiring that went on. I think that it's part and parcel of the new measure of accountability that we've introduced.

In many of these instances, of course, we have bodies, like CCACs, that are responsible for managing significant relationships with health care providers and, accordingly, are expected to submit data to us. This is the responsibility of CCACs, and we have confidence in them to do this job well.

Ms. Martel: If there's no financial information being requested in terms of the contract itself, what is the harm in making public the agencies that actually benefited and how many nurses were hired? What's the dilemma there?

Hon. Mr. Smitherman: I'm not sure that any of us said there was harm or a dilemma. You've raised something that we're happy to take a look at. All the implications of it may not be known to us, but it's something that we can take a look at.

Part of the challenge in this health care bid is, how much data are you going to ask for and who's going to get a chance to assess it? In Ontario today, there are thousands and thousands of data points where people, front-line health care providers, are spending time away from patient care to provide data samples to a variety of different people who ask for it, and a lot of it goes unanalyzed and unutilized. We have a whole strategy on information management that is being run by Steini Brown that is designed, frankly, to free front-line health care providers from spending all their time filling out paperwork.

We just want to be cautious to make sure that we're asking for the right data. You could spend all your time at the Ministry of Health sending circulars and directives out to every front-line health care provider with this question or that. What we seek to do is to take a good look at it and make sure that the stuff we desperately need is what we're asking for and that we stop asking for stuff that we're not using. As part and parcel of that process, we'll put the question you asked into the context and we'll see what we can come up with.

Ms. Martel: I don't think that would result in new or additional tasks.

Hon. Mr. Smitherman: Sure, it will.

Ms. Martel: It's information that would have to be already provided by the service provider to the CCAC. They would have to do that as part of their relationship with the CCAC.

Hon. Mr. Smitherman: You can pretend that there's no work associated with asking a CCAC to flow one more set of information or, perhaps by the time your questioning is done, 10 or 15 more sets of information to the ministry, but there is. It's not to say that it's work that we shouldn't undertake. All I'm saying is that, sensibly, what we seek to do is ask for what need and not ask for what we don't need. Right now we're asking for a lot of what we don't use. We're happy to ask for additional information if we need it. I've already acknowledged that on data, as related to nursing, we don't have it all. I'm not saying that we shouldn't do it or that we won't; I'm merely suggesting to you that we have someone in the ministry, Steini Brown, a brilliant guy by all accounts, who is charged with the responsibility, working with Hugh MacLeod, our associate deputy minister at the health results team, to simplify our data collection points. We will review this in that context. That's all I'm saying.

Ms. Martel: It's never been presented to me as an issue around a problem with data collection; it's more one of confidentiality or that, because the ministry does not hold the direct accountability of being the provider, it can't be provided in that context.

Hon. Mr. Smitherman: We're going to take a look at it, though.

Ms. Martel: OK. Let me ask some questions now about the new nurses for long-term-care facilities.

Hon. Mr. Smitherman: We say "homes."

Ms. Martel: I got a letter from the ministry at about 7:25 last night. So thank you for—

The Acting Chair (Mr. John Milloy): Ms. Martel, you have about 45 seconds left.

Ms. Martel: I want to wait, then, because I have a series of questions around this issue.

The Acting Chair: OK. Thank you. So the government—

Hon. Mr. Smitherman: Excuse me, Mr. Chair. Can I beg a minute and a half's indulgence of the committee?

The Acting Chair: I think that's agreed. The committee is in recess until the minister returns in about two minutes.

The committee recessed from 1315 to 1317.

The Acting Chair: We'll call the committee back to order. It's now the government's round.

Ms. Di Cocco: I have to say at the outset that when Minister Smitherman was speaking with a previous minister and Ms. Martel and they were talking about CMI over and over, I had to find out what the terminology actually was. Sometimes we use acronyms that are sort of in the language, but I didn't understand the language, so I had to find out what it was. Now I know.

First of all, I have to say that the ongoing complexities of managing this health care are numerous and constant, and they always provide challenges. I had the privilege of spending four days with about 30 American legislators. It was a retreat doing some training. From that experience and talking to the American legislators, I probably now appreciate our system a hundredfold more than before I went because of the challenges, certainly, that they were facing in a societal way in a more profound sense. So I have to say that as much as our system isn't perfect, I truly, truly appreciated it more and more each day that I spent with my American counterparts.

The question that I'd like to focus on is this ongoing, constant improvement of our system and equality of access, but also quality health care. I want to home in on something that was in the Romanow report regarding primary care.

One of the most exciting things I can speak to in my own riding is this notion of having, for the first time, a

satellite community health centre. A number of my constituents have no idea what this means, because we've never had a multi-disciplinary model of this type. I certainly didn't quite understand it, so I spent some time at the Forest community health centre, which is the main one, and saw how valuable this multi-disciplinary model really is and how it actually works.

In my opinion, if we are doing anything that is going to profoundly change this first access that we have in Ontario to physicians and to our family doctors, it's this multi-disciplinary model. I would like to ask you, Minister, if you can maybe expand on what you are doing in primary care in this province. I know the excitement of it happening in my area is palpable, because this is one of the most positive things we've seen in a very long time.

Hon. Mr. Smitherman: I think any one of us who has had the privilege of experiencing the community health centre model, especially if you're an MPP with the privilege of having them in your community—and I'm one of those. I often say that I learned more lessons at the Regent Park Community Health Centre than anywhere else. This is an investment of government resources that has leveraged the community to the point where we've got this beautiful initiative called Pathways to Education, which will soon be taking the country by storm, and it started at a community health centre, where you've got community governance involved.

We're working on a pretty simple premise here: If you chart it, if you look at those countries that have the best-evolved models of primary care, that is to say, models of the most basic kind of care closer to home, the bigger your investments there, the less money needs to be invested in the acute care sector, which is sometimes referred to as the sick-care system. In large measure, what we're seeking to do is transform the way we deliver health care by pushing more resource down to the community level, or pushing it upstream. Why do community health centres work? They work because they're community-based, which means they target services to people who really need the help. This is their special model. It would be beautiful to put one on every corner, but the intensive resource required makes that less possible. Our family health teams bear a lot of resemblance to community health centres.

In Ontario, our starting point was 54 community health centres. Last year, we were able to announce 10 new satellites. This fiscal year, we are announcing seven additional full community health centres and five more satellites, with more forthcoming in the balance of our term. Last year, we increased their funding by $21 million. This gave community health centres the opportunity to expand coverage to about 70,000 people. These are often people in our society who have the greatest need for health care, who have barriers related to their immigration status and their health status, with underlying rates of poverty or what have you.

I think it's appropriate to acknowledge that the NDP government made a very big commitment to community health centres. Over the period of eight years under the Conservative government, they continued to enjoy support but saw, until the very end, almost no increase in that support. We've gotten behind the community health centre model in a big way because it represents a big opportunity to address concentrated and underlying health needs for some of those Ontarians whose health circumstances are the most precarious or challenging, and I'm glad your community of Sarnia is one of those that we're in the midst of expanding some service to.

I think community health centres really are one of the most appropriate symbols of our government's commitment to expanding community-based care, and therefore working harder to keep people healthy in the first place, all of this with a view toward trying to take some of the pressure off our acute care hospitals, which don't need any more patients getting sick and which, frankly, have been spending quite a bit of their time and energy providing care for people that is more appropriately provided in the community setting.

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

Mr. Shafiq Qaadri (Etobicoke North): Minister, as you're aware, Ontario and probably most of the Western world are undergoing what's known as a demographic shift or the greying of the country. If current trend lines and trajectories continue, as they often do, it seems more and more Ontarians will be accessing and requiring home care.

Something that I'm familiar with in a medical context is that unfortunately there is a certain cohort of patients who are receiving inappropriate home care, perhaps inappropriate treatment, perhaps in an inappropriate setting. Of course, that has not only some administrative challenges—considering, for example, efficiency, a waste of taxpayers' hard-earned dollars—but also, from a medical context, suboptimal outcomes. Would you be able to elucidate for this committee what steps your ministry has been taking over the past couple of years to ensure that Ontarians receive best practices regarding home care?

Hon. Mr. Smitherman: It's a great question in the sense that it ties in well to the question that was asked prior. It's another element of a community-based investment.

Credit where credit is due. First is that we need to acknowledge that every dollar we're spending on enhancements to home care is a dollar of additional resource that's been made available by the federal government. That goes back to agreements that predate our coming to life as a government and that were signed by, I assume, then-Premier Harris probably in some cases and Premier Eves in others with Prime Minister Chrétien.

What we've been able to do as a result of these investments is enhance the amount of resource every year that's available for home care. Our investment this year has created the capacity for about 45,000 additional people to receive care in the most appropriate setting. I think that's really what you're getting at.

You represent Etobicoke North. I'm an Etobicoke kid. I was having a conversation with someone the other day.

When I needed my wisdom teeth out 25 years ago, I got my wisdom teeth taken out at Etobicoke General Hospital. We're not doing that so much in hospitals any more. This is an example of the kind of appropriate evolution that is occurring. Home care very often augments that or at least shortens the amount of time that anyone would have to spend in a hospital.

On the issue of the consistency or appropriateness of care, one of the realities we face in Ontario—and there's a bit of a theme—is that health care services have not evolved equally, I'm saddened to say. I view equity as a pretty essential principle of a public health care system. We're doing a lot of work, and we've received some tremendously powerful recommendations from the work of Elinor Caplan, herself a former Minister of Health who's been referenced here today, to try and create the capacity where our home care is delivered based more on better research and delivered in a fashion which is designed to create more continuity of care for workers and patients.

We're doing quite a good job. If you look across the breadth of the country, people would look at Ontario's record on home care—and I acknowledge that this is something that's been evolving over a period of time, where we're doing a pretty decent job. Now what we seek to do as we continue to make bigger investments there is to make sure that we're doing an equitable job and one where we've got a greater assurance that services are being provided equally across Ontario—which is not easy given the very diverse nature of Ontario and its vastness—and, at the same time, that we are paying appropriate attention to researching and disseminating those best practices so as to be able to live up to those assurances. But the bottom line is that our health care agenda is very much, as I've said quite a few times today, based on the idea that the best health care is delivered closer to home, and ideally at home, if possible.

I would just say one other thing that isn't exactly related to your question but I think would be of interest to the committee. It is that there is a broader array of services that need to be delivered at home that have, over a period of time, diminished somewhat as we focused more of our resource on post-acute care. Those are services related to what I might call "aging in place," or the ongoing need that some of our older citizens are going to require to be able to stay in their homes.

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I'm pleased to say that our ministry has also worked to prioritize and therefore allocate resources from within our budget to continue each year to expand services like Meals on Wheels, drives to appointments, other kinds of fairly easy to provide but also easily overlooked services that agreements with the federal government did not cover. We've been working to expand those, and those are volunteer-based, and such an essential element of keeping people at home for as long as possible, or ideally to the end of their lives, if that's their choice. On that point, as it relates to end of life, as that is also an area of home care that's expanding, you'll see forthcoming announcements quite soon from our government that for a lot of people will be a very logical step in the provision of care.

Mr. John Milloy (Kitchener Centre): Thank you, Minister. I'm going to get parochial just for a second because my health care knowledge and experience come from what I'm seeing in my community, where I think there are a lot of good things going on, and there's a lot of need, as there is in every community. We spoke this morning a little bit about the hospital situation in my area, obviously a lot of need: two projects, one at Grand River and one at Cambridge. I think a lot of people were very excited about the Grand River announcement that was made several weeks ago.

I appreciate that you've been put in a very tough position, having to decide between the list of projects on your desk. Although you weren't able to go ahead with Cambridge, I really appreciated your answer this morning, going into how you plan to work with the hospital moving forward.

I guess my simple question is just to ask you to expand on some of the things you said this morning. How did you find yourself in a position where you have so many of these projects on your desk and having to make the difficult choices to move forward?

Hon. Mr. Smitherman: I understand that when you're angry or frustrated, it's sometimes harder to hear all the messages. I've really sought, in my conversations with the mayor, the board chair, the CEO and also with the regional chair, to make sure that people understood very, very clearly that the Cambridge project is a good project. It's one that we agree needs to move forward, and we're disheartened that we're not in a position to do it right now. We should be careful not to throw our commitment to Cambridge too much into question, because we really believe in this hospital. We've noticed how hard they've worked to become a high-quality, well-run organization, and there have been difficult steps taken there. We've invested more than $10 million as a government in Cambridge, and I've mentioned already the new CT scanner that we've put there. I think that's an example of our commitment.

The challenges we face in Ontario are challenges long in the making, and these are three or four things that I think have contributed to why we're in a situation where we can't get as much done as we'd like, and for a lot of people, even if we're going to get it done, we're not getting it done anywhere as quickly as they'd like. Even in the case of Grand River, let's be forthright in saying that they're happy their project is going to go forward. They wish it was happening today, and it's not; it's going to be a little bit yet.

We've spoken at length about the Health Services Restructuring Commission. I don't wish to revisit it for too long, but a couple of things happened there. Firstly, they rolled around in a bunch of towns and places in Ontario and they came up with a lot of plans, and a lot of those plans had at the heart of them significant new capital investment. The projections they had around

capital investment have tended to be—I might get this slightly wrong, but I'm going to call it 30 cents on the dollar. If you look at the press releases around first announcements of hospitals, and then, four, five or six years later, tie that in to what actually happened—and I'm not just talking about Thunder Bay, where there were a whole bunch of other things at play—a lot of these numbers were just missed in the first place.

We have an infrastructure of hospitals in Ontario that is quite old—the average age I think is more than 40 years—and we have a growing province. It's a province that's growing in Kitchener-Waterloo, growing in Toronto, growing in the GTA; it's growing in almost every region of the province. This creates a bit of what I might call a tsunami effect of expectation. I don't want to belabour a point because it's a partisan point, but in the run-up to the last election there was quite an effort on the part of the Conservatives to announce a lot of projects for which—let's be frank—in retrospect, when we look at the circumstances the Provincial Auditor has uncovered, there were just no resources to reasonably expect that those projects could go forward. That's why I said that earlier this year, on January 24, in Cornwall, John Tory said, "No government should say the cheque is in anyone's back pocket. That shouldn't be the sort of thing any government member goes around saying before an election." That isn't the only time this has been commented on.

I just think in an environment where the Ontario Hospital Association has indicated that that list looks something like $8-billion long, by their number at least, it doesn't take a rocket scientist—and I don't claim to be one—to figure out that there are going to be some challenges for our province to be able to build all of that infrastructure, especially recognizing that the capital is one-time. In almost every instance, these new capital constructions beget a higher operating cost, and that too is a challenge for any government that is operating within real fiscal constraints. I hope that's helpful.

We continue to work, and I send this message to the people of Cambridge as often as I can, that it is not a matter of "if only" when related to their hospital. We know there are some challenges they're facing there. We've been very clear that any time the hospital or the mayor need to meet with me, I'll be available to meet with them as we seek some resolution to this, which acknowledges that this is a community with currently unmet needs.

The Vice-Chair: It's time now for the opposition party.

Mrs. Witmer: I think I'll just continue with the LHINs for a minute. As it stands right now, there is still a great deal of angst simply because there is no legislation and there has been little information communicated as to the roles and responsibilities and the actual plan for LHINs. In fact, one might ask, is their mandate going to be to coordinate health activities—for example, hospitals, CCACs, cancer care, cardiac care—or are they going to be in a position to actually issue directives to hospitals to cut services or amalgamate services with another hospital? I'd just like to hear from you what the actual plan for the LHINs is going to be and what type of power they will have. Are they also going to be making the allocations to each of the health agencies and service providers in their area?

Hon. Mr. Smitherman: I find it interesting that the honourable member would say that there's angst. Perhaps it's on her part, because she didn't offer up where that angst was coming from, so maybe in her supplementary she could tell me a bit more about that.

I met a lot of health care providers who I would say are on the bandwagon and are enthusiastic about the idea that, for once in Ontario, we might have a mechanism to plan for the integration and coordination of services and have responsibility for funding under one roof. You choose to label that as something different, but it's interesting that past colleagues, who shared the role that you did in the same government as you, have acknowledged that Ontario has been behind the curve in terms of creating some semblance of health care organization that has some boundaries within which health care providers can be expected to come together.

I will argue strenuously that your point on little communication misses the mark entirely. Astonishingly, last year we had 4,400 different health care providers involved in helping to lead our work with respect to local health integration networks. In the last month or two alone, 1,500 health care providers have come together with the leadership of local health integration networks as we seek to build more of a system together.

To your specific points about what will be in the legislation, I'm not here today to speculate about that. I've clearly outlined what the overall initiative will be with respect to local health integration networks. It answers many of the questions you've asked. As we bring our legislation forward to the House before Christmas, as I answered to the honourable member earlier, one should fully anticipate that this is a model that is designed to take significant power that currently resides in that office, which three of us here have had the privilege of serving in, or from, and push that down to the community level, based on a pretty simple premise: that in an environment where resources will always be more scarce than any of us would prefer, people closer to the action, from the local community, be given the power and responsibility for making decisions about a health care system that is, after all, ours—all of ours. I think that's why it is so important to move forward, on this basis, with a made-in-Ontario model that keeps that principle of community-based governance alive.

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Mrs. Witmer: Since you didn't answer the question as to the plan or the roles or responsibilities, or whether or not they're going to coordinate or dictate activities, I would ask you, what are their budgets going to be?

Hon. Mr. Smitherman: Their budgets will consist of flow-through. Again, this is a transition of power: power that's currently exercised at the ministry level being

exercised at the community level. We've been clear in saying that that responsibility, at least on a preliminary basis, will be related to several functional areas: long-term care, community care access centres, hospitals and community-based organizations providing mental health and addiction treatment. The powers and responsibilities will be substantial. We're very proud to be a government that is prepared to push these responsibilities down to the community level and engage in a new kind of conversation.

You choose to continue to characterize everything in the old conversation—the one that you're used to—with a word like "dictate." We're operating on the view that this is our health care system, that it belongs to 12 million Ontarians and that each of them, frankly, has an obligation and an opportunity to be more aware and involved. That's why we're also creating an Ontario Health Quality Council, which can help people make the health care discussion more accessible to them. Having the opportunity for the health care discussion to go on in a local community rather than in a corner office at 80 Grosvenor Street, I think, is a tremendously important advance.

Sometimes I get frustrated, because we operate in an environment in health care where a change is easily conveyed as a cut. This is the language of some stakeholders, and it's designed to send fear through the hearts of Ontarians. But I think—

Mr. Wilson: You say things like that every day.

Hon. Mr. Smitherman: Is this in order, Mr. Chair?

Mr. Wilson: Every day you say that.

The Vice-Chair: One person at a time.

Hon. Mr. Smitherman: Do you want some evidence of how you cut health care? I had a question earlier about Lakeridge hospital. I told how we had increased their funding by $24 million. Between 1995-96 and 1997-98—I think you were in there somewhere, weren't you?—Lakeridge had its base budget cut by 9.2%, $13 million. You did cut, sir.

Mrs. Witmer: We added $10 billion to the health care budget over the time we were in office. We were also very proud to create positions for over 12,000 nurses and to advance the hiring of additional doctors. Also, we were the ones who announced the new school for Thunder Bay and Sudbury. We're very proud of our track record, we're very proud of the innovation we introduced and we're very proud of the change we undertook. In fact, we were the ones who had the courage to introduce P3s. You can see what has happened now. You've had to admit as well that you've got to use private capital in order to construct hospitals.

I'd like to go to hospital funding. Earlier this year, your Premier said that when it comes to funding for hospitals, we are last in Canada. I guess I would ask, is it your plan to bring Ontario's hospitals out of this funding basement, compared to the rest of Canada? If you say no, I'd like to know why, since even Premier McGuinty acknowledges that we are last.

Hon. Mr. Smitherman: Firstly, if we take that away, then the primary messaging of the Ontario Hospital Association, which is that we're most efficient, would be at risk.

A few points on this that I think are noteworthy: Firstly, the Premier's conversation about the status of Ontario investment—he wasn't speaking only about hospitals; I believe post-secondary education, where we were struggling similarly, was noted—was in the context of gaining support to address the $23-billion gap. I think it's appropriate that the Premier would advance this to help people understand that, in the circumstances, Ontario is a big and strong province, but our ability to provide services to Ontarians is being impacted by the amount of resources Ontarians are contributing to the government of Canada. That situation, so long as the $23-billion imbalance remains, is very difficult to address. How do I know it's very difficult to address? Because only today your leader—John Tory, who, by the way, has yet to indicate where his $240-million proposed cut to health care this year would be funded from—has now indicated that part and parcel of your health platform in the run-up to the next election will be to seek ongoing improvements of efficiency in Ontario hospitals.

I think it's important to acknowledge that what our government has done is operate in a fashion where we have made complementary investments across the breadth of health care. We have not taken one sector at the expense of all others and said, "Here, you have all the money." If we look at the trend of your party while in office, it was hospitals almost to the exclusion of all other services. How else can we explain the fact that when our government came to office, community-based mental health organizations, as one example, had not seen a penny of increase since before Bob Rae's hair turned grey.

I think this really does stand out as a stark contrast between our government and your government.

I'm proud that we were able to contribute 4.7% as an increase to Ontario's hospitals this year. That was higher than the number they had been expecting. What I'm prouder of still is that we are a government that has gone beyond the talk and moved forward in a fashion where hospitals across Ontario now have a source of predictable and stable funding that allows them to plan. This long-awaited and much-asked-for commitment to longer term funding is part and parcel of our commitment and an acknowledgement that it's not easy to run a hospital; it's a very challenging circumstance. Accordingly, we're proud of the record we have around the investments we've been able to make in our hospitals while at the same time making important complementary investments that have the effect of taking pressure off our hospitals.

Mrs. Witmer: The reality is that it's fine to make the complementary investments, and it's absolutely essential that you do, because, as you know, we established that continuum of care with 20,000 new long-term-care beds and investment in community care and health promotion, but that doesn't change the fact that our hospitals in this province are still in the basement when it comes to funding, and I've heard you say that you're not going to change that situation.

As a result, as you know, we currently have probably about half of the hospitals in Ontario going through the seven-step process to balance their budgets, and they haven't been able to. As you know, it's called the hospital annual planning submission. Step one is revenue generation, and the steps after that become increasingly severe. It calls for the consolidation and elimination of non-clinical services, cutting of non-clinical staff and discharging patients from hospital more quickly, all the way up to steps six and seven, which talk about program consolidation and elimination.

Since there are certainly many hospitals still struggling today to balance their budgets and, as we heard this morning as well, there have been announcements as far as program cuts and staff are concerned, are you prepared to continue to force hospitals to consolidate, cut patient services and lay off staff such as nurses?

Hon. Mr. Smitherman: Well, you put a lot in there. The first thing you did was decide that impacts that are non-clinical in nature are severe. I ask you how you rationalize, on the same day that your leader has said we need to become more efficient in hospitals, which presumably is to focus your energy on trying to reduce the amount you spend on overhead like administration, that you then characterize the same efforts on the part of our government as severe. I think that's something you should answer to.

The reality is, as well, that you've—

Mrs. Witmer: I'm not the minister.

Hon. Mr. Smitherman: It still doesn't mean that in the context of a political discussion—

Mr. Wilson: What a condescending tone you have.

Hon. Mr. Smitherman: —you shouldn't be held accountable for that. I'm trying to rationalize your party's participation in this debate.

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On the issue of consolidation, no one should pretend that if you take two programs and bring them together, and the same volume of services is being provided, that's a cut. Yet, I think that seems to be the inclination with respect to the way you brought that question forward.

Here's the bottom line: In Ontario, we're moving to a situation where we have created a reasonable expectation that if you have the high-end responsibility of being on a board or being the CEO of a hospital, you have an obligation to live within available means. This is no different from the messaging that any health minister in any other government has brought forward. Our determination to make progress on it may be the thing that sets us apart, and progress is being made: 90 hospitals in Ontario are currently in balance or on their way to being appropriately in balance, and many more of them have made tremendous progress toward that. The lion's share of progress has been made in a fashion which has not had any impact on the provision of clinical services.

I think that our record as relates to an accountability agenda and our hospitals is one of the strongest indications to Ontarians that we're serious about the idea that we should live within our means, that we should balance our budgets. Accordingly, we're going to continue on a process to get us there.

Earlier I had a chance to talk about program consolidation in the context of clinical benefit and of being able to more easily adopt and adapt new technologies. I'll give you one small example: Shortly, in the city of Toronto we'll be opening a new, not-for-profit clinic, called the Kensington clinic that will provide for the consolidation of a significant number of cataract surgeries. We're going to stop the process whereby our tertiary care hospitals, the high end of the health care system, are providing cataract surgery, which most people would agree is not something that requires a person to go into a tertiary care environment in most cases. This is an example of program consolidation where the volumes will come together—in fact, we'll add to them—and the clinical outcomes and benefits to patients in Ontario will be advanced. That is not something to fear; rather, it is something to celebrate.

Mr. Wilson: I want to say hello to Frances Barker at home, who lives at R.R. 2, New Lowell. I know that she's watching these proceedings on cable. She asked me to read this letter to you, which was sent to me in June. It says:

"My name is Frances Barker and I am writing on behalf of my husband, Laverne Barker. We live at R.R. 2, New Lowell, five miles east of Creemore. Laverne needs a hip replacement and has been waiting a year (since I called Smitherman's office) and still no date yet. I have dealt with various agencies and offices and received a wide array of excuses explaining the delay.

"If we had the money we could go to the States or Japan and have it done immediately with no waiting. But as low-income seniors ($23,000 total) we are forced into playing this evil, archaic waiting game.

"If a horse or any other farm animal was in this much pain he would put down. Every day on TV we see reports of the SPCA investigating and charges laid for cruelty to animals. Well, what do you call this!!!?

"He is over the wall in pain and consumes large amounts of pain medication and is very depressed and at times suicidal, begging for something to 'end all this once and for all.'

"I know personally of other people who had this procedure performed with a wait time of two to three months in Toronto at St. Mike's and also orthopaedic and arthritic institutions. We go to RVH in Barrie because of proximity to home.

"Please, Mr. Wilson, can you help us? I am a senior citizen myself (with my own physical limitations). I cannot stand the mental anguish resulting from this much longer. I'm at my wits' end and just have to walk away at times in order to not say something I regret.

"Sincerely,

"Frances Barker"

She wrote that in June. Minister, I'm wondering if you could have someone give her a call. Her phone number is here. I forwarded this letter to you on June 9, and still haven't received a response.

Hon. Mr. Smitherman: I think that the response I offer to Frances and Laverne is to acknowledge that this is an area with considerable challenge. It is why we campaigned on wait times, and I think that you're helping to make the point for the necessity of investing appropriate resources to increase volumes, but also to learn what we can do to enhance our capacity to deliver these services.

Let's speak very specifically, as you have: As a result of the investments we've made just in the last little while at the Royal Victoria Hospital, in addition to the extraordinary amount of new capacity they have around MRIs, in addition to the additional cataract surgeries they have and the additional cancer surgeries they will perform, they will perform 100 additional hip and knee surgeries as part and parcel of our government's increase of more than 6,000 hip and knee surgeries, and more to the point, on the issue of the wait time challenges that are there.

There is no doubt that in an environment like ours, where we have an aging population, our ability to hit this demographic curve is going to require a lot of resourcefulness on the part of the Ontario health care system. One very powerful tool in that regard is forthcoming, as I've already spoken about today, and that is around the wait times information being posted on a case-by-case basis, so that individuals like the Barkers would be in a position to determine whether what they've heard anecdotally, and we've all heard these storylines, is in fact true. I think that the investments we're making are paying off. More people are accessing hips and knees, to the point where our capacity to do these is becoming limited by the time available from orthopaedic surgeons.

But we will continue to dedicate ourselves to improving those circumstances, and I think it's appropriate that this constituent deal with her MPP in the same fashion as my constituents deal with me. We'll make that information available on Web sites, and I think it's going to be a significant way to inform the debate. I give her the assurance that we're not done yet. We're going to continue to work to address these wait times, which are a well-known challenge in our province and across the country.

The Vice-Chair: Thank you very much, Minister. The time now moves to the NDP.

Ms. Martel: Minister, in my last rotation your last comment to me was, "We use 'homes.'" I should point out to you a letter I received from your staff on July 29, 2005, where the first paragraph reads, and I'm quoting, "I am replying to your request for access to information concerning the second survey of baseline data for staffing in long-term-care facilities." I don't think you're in a very good position to point fingers, Minister.

Hon. Mr. Smitherman: Did I sign that letter?

Ms. Martel: It's from your ministry; you said "we": "We use homes."

Hon. Mr. Smitherman: —the deputy and me.

Ms. Martel: Maybe you'd want to clarify with all your staff about the terminology. But let me get to the letter in question, which was a result of my making two freedom-of-information requests with respect to nursing numbers in long-term-care homes.

The first was a request for baseline data which the ministry said it was gathering for staffing in long-term-care homes before an allocation of funding in October 2004. The second was baseline data that they were gathering in a survey after the allocation of funding in October. The ministry said that they were doing this work and the surveys should be ready, and that was in public accounts in May.

The letter that I have talks about the positions as a consequence of the staffing after October 1. I would still be very interested in getting the information with respect to the first survey, what the situation was in long-term-care homes before the allocation of funding. I understand that you were gathering that information, at least you told that to the public accounts committee, and I would still like that information. But with respect to this letter that I received last night, it makes comments with respect to nursing staff and other staff, personal support workers etc. The clarification I would like is, because not all the information is complete, can you tell me if 78% of long-term-care homes have created 1,627 full-time equivalents, which would mean that there are some more to be created, or is this the total that has been created, 1,627, and you still need to verify that that information is true with 20% of the homes?

Hon. Mr. Smitherman: It's my understanding that the number, 1,627, reflects information based on 78% of the homes that have reported. That's accurate?

Ms. Martel: He says that it is. Then if that's—

Hon. Mr. Smitherman: His letter from last night does say "homes," so we've made progress since July.

Ms. Martel: Very good. Let me look at the information with respect to the nursing staff in particular. If it is the case that right now you have 375 full-time equivalents for 78% of the homes, it seems to me that there's not really a way that the ministry is going to meet its target of 600 FTEs, of new nurses, with just the balance of 22% unless you have some enormous hiring of 22%, and I don't think that's possible.

1400

Hon. Mr. Smitherman: There are two pieces to it. The first is that we can't assume that the 78% of those that reported are done. We still expect and anticipate some growth in the 78% and the number from the 22%. I can't predict at the moment whether we're going to nail 600 right on, fall short or exceed it. The data are still forthcoming and the subsequent survey should give us a clearer picture of what that number looks like, but it's the combination of those two things. We'll still produce additional nursing jobs.

Ms. Martel: When do you expect that data from the balance of 22% and whatever additional information is coming from 78% to actually be available?

Mr. Sapsford: That would come in the next survey and that will be based on the end of June 2005 in terms of the numbers. That will be available in mid-November.

Ms. Martel: Deputy, do you have the information available to the ministry now about what the staffing numbers were before the money was actually flowed in October?

Mr. Sapsford: It would be based on an estimate, January to June 2004, so that would be prior to the first allocation of this. The calculation of the 375 additional nurses is from that baseline position. It's a calculation of increase prior to the new funding going forward and then subsequent to that.

Ms. Martel: All right, then I would ask for the data before the money actually started to flow. Is that available in a public format that can be released to me?

Mr. Sapsford: Sure. We can provide that information.

Ms. Martel: Sorry, you did tell me and I just forget; you're expecting the rest of the data, the balance of the data for the second baseline survey, by—

Mr. Sapsford: In November.

Ms. Martel: I would appreciate receiving an update at that time to follow on the letter that I just received.

Can I ask as well, because I think the commitment was fairly clear: 2,000 new staff in long-term care homes, 600 of those to be nurses. If the ministry doesn't hit the target—and I would say the nursing numbers look particularly iffy—what are the plans to try and find out where that money went and to make sure those actual positions are filled?

Hon. Mr. Smitherman: It calls for speculation, so we'll address that when we have data to back it up.

Ms. Martel: So by November, we should have some sense of what those numbers are, and then if they're short, what the ministry is going to do. Would that be correct?

Hon. Mr. Smitherman: Yes.

Ms. Martel: Let me deal with some other nursing numbers, if I might. The announcement made in June with respect to $28 million to long-term-care homes, what is the number of new positions you expect to be created as a consequence of that money, both nurses and other long-term-care-home staff?

Hon. Mr. Smitherman: I'm at odds over which—could you give some more detail about the $28 million?

Ms. Martel: You made a second announcement of funding for long-term-care homes in July. It added up to about $28 million. It was an increase of about $1.01 per day to the nursing envelope.

Hon. Mr. Smitherman: I think this is an amount of resource that does not have the expectation of a particular implication on staffing tied to it. Someone will tell me if I'm misreading this, but I don't believe we had put an expectation associated with that. This was to recognize that there are increasing pressures.

Ms. Martel: The 2,000 staff that were promised is really tied to the October announcement, then?

Hon. Mr. Smitherman: Yes.

Ms. Martel: You're not expecting to catch up or fill in with the additional $28 million that was announced?

Hon. Mr. Smitherman: Right.

Ms. Martel: OK. Let me ask then about nursing positions in post-secondary institutions. I would like to get a breakdown if I can—this might have to be provided by the nursing secretariat. In the release that Mr. Fonseca put out on September 15, he said very clearly, "We have increased the number of new graduate nursing positions." Can I ask exactly what that means? If I look at the new entrants to nursing programs, there's actually been a decline. The most recent figures I have are 2003-04. Was that a reference to new entrants to programs?

Hon. Mr. Smitherman: I haven't seen his release. Like you suggested, we'll take that one under advisement and, if we could, endeavour to get back to the member.

Ms. Martel: The nursing secretariat wouldn't have that information right now? She was listed to be here; maybe she's not. I'm not sure.

Ms. Sue Matthews: I'm Sue Matthews, the provincial chief nursing officer. It's my understanding that those are the new-graduate positions we talked about earlier, but I will check that and get back to you.

Ms. Martel: The new-graduate positions.

Hon. Mr. Smitherman: It may have to do with the commitments that were in the budget, which included an initiative related to northern Ontario. We will endeavour to firm all that up.

Ms. Martel: If that's going to be the situation, I wonder if I can get some new graduate numbers from a previous time period, which would be 2003-04, and then 2004-05. I'm assuming that your reference is to 2004-05, the most recent. OK.

I'd like some additional information with respect to these seats all together, so if I might just break this down, how many seats were funded for nursing programs in 2003-04?

Hon. Mr. Smitherman: I think these are questions for the Ministry of Training, Colleges and Universities. We'll endeavour to get good quality answers around them, and obviously we're working in partnership, but these are functions of another ministry.

Ms. Martel: I apologize. I thought the nursing secretariat would have that. I'll just give you the rest of them: the seats that were actually filled, so the funded seats for that time period, and how many graduates in both of those time periods. That would be great.

My other question also had to do with the late-career nursing money that was announced in July, the $25 million allocated to hospitals and the $3 million to long-term-care homes. How was that tracked and do you normally provide a breakdown by both the hospitals and the homes? I'm assuming you're going to use the same tracking as you put in place last year for the same allocation, with a different figure of money.

Mr. Sapsford: Yes. My understanding is that it's on application. So we would accept proposals and then track with the individual institution, whether it's a hospital or a long-term-care home, as to the positions and how they're followed up, and we would expect a report back.

Ms. Martel: Where are you in the reporting mechanism? Are you just finishing up with last year's allocation of money?

Mr. Sapsford: Yes, for the current year.

Ms. Martel: No, but you had money that was announced and allocated last fiscal year for career nurses, correct? Do you have figures on what the final situation was for the applications that went out last year?

Mr. Sapsford: No, we wouldn't have that now but that would be part of the work that we'll do this year. I'll check with staff in terms of the precise timeline.

Ms. Martel: My apologies, then. When did the applications go out? In September?

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

Ms. Martel: All right. Before I wrap up on nurses, I wonder if I can just get this from the Minister: At the start, when I was asking about numbers, you said you had different categories in the numbers that the ministry was using for full-time positions. Can I just get those from you again? I think they're the same as the ones I have, but if you could—

Hon. Mr. Smitherman: Yes. I think we've covered them: hospitals, long-term-care homes, home care—under home care needs to be the broader community as well. So far, we haven't captured increased employment in public health, where we anticipate increased nursing employment. We haven't captured it in terms of our mental health initiatives, where we know through things like ACT teams that there have been increases in nursing employment. We know there will be significant nursing employment related to family health teams for new positions, so that's one part of it, and then the new grad piece.

Ms. Martel: But you're using some set figures for created positions, so can I get the breakdown of the 3,002 positions, I think it was, created that you referenced this morning?

Hon. Mr. Smitherman: It was 3,062. I'll give that to you now: hospitals, 1,202; long-term care, 375 to date; home care, 485; family health teams are reporting zero for now, with high expectations to come; and the new-grad piece is the 1,000 that we spoke about extensively this morning.

1410

Ms. Martel: I'd like to ask some questions on the money that was allocated for bed lifts. I gather that about $110 million was allocated in 2004-05.

Hon. Mr. Smitherman: The allocation around bed lifts was over at least two, and perhaps three, fiscal years. Some of it certainly was in 2003-04, just FYI.

Ms. Martel: Was that allocated strictly for the lift itself, or if a hospital or long-term-care home had to do some renovations to make that work? How did that work?

Hon. Mr. Smitherman: It was a capital allocation on a per lift basis with an established cost. I don't know exactly what ancillary costs might have been associated with it, but for the most part these bed lifts can be easily installed in environments without construction. I believe the per unit cost that we provided was satisfactory for long-term-care homes and hospitals to be able to contract for their installation.

Ms. Martel: Do you have the figures for 2003-04 on how much of that allocation was actually spent? How many hospitals and long-term-care homes used it?

Hon. Mr. Smitherman: We'll happily provide that to you. I'm pretty sure we can get that down to per environment—I'm trying not to use the word "institution," because I don't think of long-term care as institutions. I believe we can show you a list of which of those entities received an allocation and had an installation.

Ms. Martel: Can I be clear: Was the allocation essentially divided three ways over three years, or was there more going out in the first fiscal year?

Hon. Mr. Smitherman: The lion's share of it was in the 2004-05 fiscal year. We'll give you the breakdown on each of those.

Ms. Martel: That would be very useful.

Hon. Mr. Smitherman: I should just say too that there was some opportunity, especially in the 2003-04 allocation, I think, for other care and safety-related—while the lion's share was focused on ceiling-mounted bed lifts, some other kinds of equipment were also included; in some instances, mobile lifts.

Ms. Martel: That information would be helpful. Just on the area of equipment, if I might, the ministry made a one-time allocation of $11 million for hospitals to purchase safety-engineered medical devices. You will know that I have a private member's bill that is in committee, and has been in committee for some time now, which I am afraid will be lost with the new session and which I regret would be lost. It seems to me that if the ministry saw the value of making an allocation of some $11 million to hospitals even on a one-time basis, there must be some value to recognizing that needle-stick injuries are a significant problem not only in our hospital system, but in long-term-care homes and doctors' offices as well, and that we could be doing more to make sure we avoid those. Using safety-engineered devices is a sure way to avoid those kinds of accidents in any of those working environments.

There's been a lot of lobbying that has gone on to your colleague at the Ministry of Labour previous to the government's announcement. I can't confirm whether there was lobbying to you directly, but what is your position with respect to making the use of safety-engineered devices mandatory in prescribed workplaces—like they're doing in Alberta, like they've announced they're going to do in Manitoba, like they're doing in the States—so that we're sure we protect workers from injuries that really are preventable?

Hon. Mr. Smitherman: I think two or three points are relevant. Firstly, one of the first acts of the former Minister of Labour was to create—I don't know if he used the word "table" but, related to the health care sectors, bringing together a variety of leaders to look at things. We've been very grateful for the work that all have been doing on that.

The one-time nature of the $11-million investment shouldn't be missed in the sense that if you look at Toronto East General Hospital, one I'm kind of familiar with, there are one-time costs associated with the implementation of this kind of a program, and they were able to implement that.

I would just acknowledge that this is an area where there is more opportunity for progress. We are not running shy on places where we have opportunities for

good-quality investment. Our dedication to the health and safety of our nurses is well reflected in the commitment we made on bed lifts and also to changing work practices, especially for older nurses, to literally try to take some of the strain off their backs.

In the hospital environment, there are different places where it makes more sense to go needle-stick-free, or safety-engineered devices. We're going to continue to work with the hospital sector and nursing groups with a view toward making more progress on this, but I think it's fair to say we don't have all of the resolution to that as yet.

Ms. Martel: You mentioned that the Minister of Labour set up tables with health care workers, and my understanding is that the incidents of needle-stick injuries and mandatory use of safety-engineered devices was rated as a priority, probably the number one priority, with the health care groups that were involved. So this is a major issue for them and it needs to move beyond the discussion at the table with the Ministry of Labour to a recognition that we can protect health care workers—nurses and others. We can certainly protect people who come into contact with these devices downstream who have nothing to do with health care but end up being stabbed by a needle when they're cleaning out the garbage. This happens as well. We should really look at, if not trying to deal with my private member's bill, then a government bill that would have this on the table for discussion and debate.

Hon. Mr. Smitherman: It's important to acknowledge that it has gone beyond the discussion point to where our government, the first in the history of Ontario, has provided some resource to begin with the implementation of it. I'm the first to acknowledge that there's more work to be done there, but I'm the first to acknowledge that I have more work to do on a wide variety of files, and this would be one of them. With respect to the commitments that we've made to nursing, I think they stand well in terms of the investments we've made and the recognition that the health care workplace environment is one that we always have strived and should continue to strive to make more safe.

I don't disagree with much of what you've expressed. We've got to keep pounding away on it.

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

Mr. Phil McNeely (Ottawa–Orléans): My question relates to wait times. In my mind, wait times reflect the general level of health care in the community. My question is specific to Ottawa–Orléans and the Champlain district, of which Ottawa forms the largest part. The ICES report on wait times for the 2003-04 period, the last year of the former government, came out in April 2005 and therefore reflects the situation when you assumed this ministry. As you and we in Ottawa already knew, Ottawa wait times were the worst in the province when we took over as government. This was the legacy of John Baird, Norm Sterling and Mike Harris. They seemed to cut deeper in Ottawa than in other areas of the province. ICES showed Ottawa wait times were the longest—14th out of 14—and absolutely the worst in the province.

Information comparing wait times was not available until the ICES report came out, but anecdotal evidence was available and you, and our government took action. In Ottawa, you confirmed that the CHEO cardiac unit would stay and prosper in Ottawa, and that was great news for us. You provided two new MRIs, one for the Queensway-Carleton Hospital and one in my community for the Montfort, increasing MRI exams by 11,000 per year. You provided one of the most efficient hospitals in our area, the Montfort, a hospital that serves both the francophone community in Ottawa–Orléans and all of my community, $125 million to expand—wonderful news for Ottawa–Orléans residents. You've increased hip and knee surgeries by 400, as many as they could do. You've increased cancer surgeries at Ottawa hospitals by 500 in 2005. You've increased cardiac procedures by 790 in 2005. There's been much good news for Ottawa in the past two years, which follows the period of provincial supervision and threatened and actual cuts.

Minister, health care equity across this province is important to all of us. I've noticed improvements in diagnostic testing already in Ottawa and shorter wait times. So I believe actions taken by you and the McGuinty government are showing good results. Can you tell me what changes you are making in the monitoring and reporting of wait times, when the next reporting of wait times across the province will be made and, where there is significant inequity, some of the actions you'll be taking to ensure all areas in this province continue to see improved health care?

1420

Hon. Mr. Smitherman: I thank the member for the question and for placing it that way. I'm not sure I'm supposed to say this, but your passion around progress on this is intense.

I think a few points here are really crucial. The first is that this is the power of local health integration networks. But what impressed me more than anything else when ICES released the report we commissioned them to do was that the information on a local health integration network was provided on a local health integration network basis. If you looked at the regional news coverage coming out of Windsor for the folks in Erie-St. Clair, for the very first time the people in Champlain were able to take this huge health care story and have more of a geographic or regional take on it. That is about the beginning of a more accessible conversation about health care. To me, that stands as a very strong signal that local health integration networks are already powerful, because they're going to change the nature of the debate.

The challenge we face should not be misstated. It's easy in the abstract to look at a bunch of numbers and say, "You need to shift that number over here and that number over here." That's easy to say in the abstract. But the challenge you quickly run into is that you have health care organizations, health care providers, actual clinicians, doctors and everybody else aligned around current service delivery patterns. So it comes to us, in the new investments we make, that we should seek to make those

investments consistent with what we know about regional inequity. This is where the rub really begins.

In Ottawa today, or in the Champlain area today—I should be more precise—we have 169, on the most recent wait time resource allocation that we did. It would have been our preference, in addition to what we did allocate, to allocate 169 hip and knee replacements to the Champlain district. But there's a problem. In the current configuration of the Champlain district, with the challenges around anaesthetists and the time available by orthopaedic surgeons—I'm not just talking about the hospitals in Ottawa but throughout the Champlain region—we have not had the capacity available to give Champlain all of what our information dictates should be available. Then we looked logically to the next local health integration network over and, similarly, no capacity exists there. So we're informed on an evidence basis for the first time. It creates the catalyst for more of a community conversation and gives us the opportunity to make allocations in a fashion consistent with the principle of equity, and that is our determination.

As we seek to do it, we confront very practical barriers, many of them around health human resources. But we don't rest on that point. Hugh MacLeod, our associate deputy minister, who is responsible for the health results team and who works with Dr. Glynn and Dr. Hudson, then looks to go the next step: How do we involve experts to unlock some of these circumstances? What's a small example of this?

There are places in Ontario that have perfected—I'm going to use an example that I believe I will get right. Toronto Western Hospital on Bathurst Street has perfected a new model of hip and knee replacement that requires less time in hospital and getting on more quickly to the comprehensive physiotherapy. Shortening the stay may prove to be one opportunity to enhance capacity. Part of what we seek to do with the good work of these three gentlemen and through these expert panels—I call that the system helping the system—is to unlock those problems. Our determination to address these things with a greater degree of equity is there.

Local health integration networks: We're going to continue to collect information on that basis and inform the local conversation. But we will soon discover there are challenges that we have to find solutions to unlock. Our determination to get that fixed and to be more equitable drives our passion to unlock new solutions to address challenges.

Mr. Jim Brownell (Stormont–Dundas–Charlottenburgh): I would like to reflect on the comment you made this morning where you said, "LHINs are going to help us build a system...." Very often since you took over this ministry—in the very first week I heard you talk three times about the system that you couldn't find. You always had an expression and you ended that expression by saying that it might not be grammatically correct.

You've alluded to the fact that health care providers had worked in silos for far too long, that constituents were having trouble making their way through a tangled web as they worked to get access to health care. I'm just wondering, with LHINs, how will these local health integration networks overcome the problems that have been experienced in the past and help to really create that system that hasn't been there in the past?

Hon. Mr. Smitherman: The expression that I always use is, "The more I look for a health care system, the less of a system I see." I know the grammar is a little twitchy there, but it's a theme that I revisit all the time. We use the word "system" a lot, but if we apply our understanding of what the word "system" means, then we would not have these kinds of anomalies. I'll just give you a couple that I think are startling.

When Dr.—I keep wanting to call Hugh MacLeod a doctor. He won't mind. When Hugh MacLeod first started to do work around the health results team and our wait times in particular, we sought to be in a position to allocate additional resources. We knew that we wanted to do a bunch more cataracts, so we asked all those providers of cataract surgery in Ontario to tell us, "How many more could you do, and at what price would you do them?" This is kind of a novel concept for health care. The surveys came back and said there were tonnes of additional volume available, and we've eaten up a good chunk of that, and the range in price per eye was from $450 to over $2,000 for the same procedure in the same Ontario health care system.

We asked later on, "What is your throughput on your MRIs?" You know that we've funded MRIs typically as an eight-hour package, 40 hours a week, but we never established an expectation of what the flow-through would be, what the output would be. So we got this expert panel together, and they determined that it was appropriate that you do 1.25 MRIs per hour, and therefore you can determine what your hours are buying you. When we asked hospitals to apply that standard created by the system itself against what they were actually doing, the range in efficiency from the same Ontario health care system was 33% to 125%, another piece of evidence, I think, that the word "system" is a bit overused.

I should give some credit here. There are lots of places in Ontario where health care services have come together and are better integrated now than they were a while ago. That's not to suggest that we have overcome what is widely known as the silo mentality. What we really do with local health integration networks is seek to topple those silos on to their side and give one body made up of people from the local community closer to the action more capacity to help lead in the planning, integration and funding of health care in a fashion that recognizes the interdependent nature of the delivery of health care services, which recognizes fundamentally that, as a patient, it's no good to me to get good care in a hospital if, when I leave that hospital, there's some big disruption with accessing services through the community care access centres. As I've travelled around Ontario, I have found those places where the community care access centre is in the hospital and engaged, and I have found those places where it isn't.

All of this stands as evidence, I think, that we haven't lived up to our use of the word "system." With local health integration networks, we simply seek to create more system thinking and performance that builds on the idea that we are all in it together for the patient—one patient. So we put that patient at the centre of care, we create a firm—not a boundary that a patient can't make their way through.

My mother lives in Jim Wilson's riding, on the mountain in Collingwood, and her doctor is in Etobicoke, which is where we were from. My mom continued to be able to get services like that. But what we seek to do is, by creating some regional structure—a word that I sometimes stay away from—by collecting data on a consistent basis within it and bringing those health care providers in that same geographic area together, we can encourage them to work better together.

A small anecdote: During one of the sessions held where health care providers came together with people from the LHINs in the Niagara area, two health care providers who worked in different addiction treatment organizations in the Niagara Peninsula had spoken on the phone many times over the 10 years that they were both working in this same area, but they had never met. They had never come together face to face. Maybe that seems like a small thing, but to me it's a big thing.

What we're creating is a dynamic for a new conversation and a new way of making decisions based on the reality that our resources are more scarce than any of us would prefer. Accordingly, it's appropriate to make sure that people closer to the action at the local level are exercising appropriate judgment around what local priorities require resourcing over others. This is the other piece that gets at Phil McNeely's question about equitable services.

1430

The deputy has a very different experience, both as a long-term bureaucrat and as someone who's been very involved in a variety of health-provider roles. It might be helpful to get some further words on that from him. Do we have time for that?

The Vice-Chair: Sure, absolutely. There are five minutes left.

Mr. Sapsford: I think it's important to understand that many health delivery agencies are focused on their mandates. Some of our health agencies, such as hospitals, have statutory mandates where their role is quite clearly defined. So when it comes to looking at local service delivery, naturally those agencies look to their prime mandate, and where patients cross their boundaries, they look to others to do it and basically stay focused on their own primary role.

If one looks at our health system, what we don't have in our health system is that focus at the local level that looks across all agencies of delivery and spends a great deal of time and energy looking at how the system elements work together. Many people looked at the Ministry of Health to do that as a ministry. This system is too big, and the province is too big and complicated to expect that that can be done from a central location.

As the minister has said, I think it's very important that people recognize that there is a huge amount of interrelationship between existing agencies that needs to be planned, managed and funded, and that really has been a gap in our health system which LHINs are expected to fund. It is going to be a different model in this province from other provinces. Many others have gone the full direction to actually include the employment of all health care workers in an area as part of the role of the regional agency. That, of course, brings a different level of responsibility, a different set of complications and issues that need to be addressed. I think the model here is going to continue to rely on local boards of hospitals, local health volunteer agencies, as important contributions to how our system operates. From my perspective, for local hospital boards there is still a very real and vital role that they play in managing their own activities, their own planning and strategy and the quality of care in their agencies and institutions. This model for LHINs will not directly interfere with their responsibilities.

I think it's an important change that will take some time to put into place, but over a period of time I would expect that the quality of our service delivery and planning at the local level with improve as a result of that.

The Vice-Chair: There are still a couple of minutes left on this side, if you want to extend the answer.

Any further questions? No. In that case, it goes to the opposition.

Mrs. Witmer: I had one more question from the last round, and it had to do with the hospitals in Ontario.

There had been an indication from the province on January 17 of this year that that would be the final bailout. I'd like to know, how much money did the province provide hospitals with after that January 17 allocation, when were the allocations made, and what were the allocations made for?

Hon. Mr. Smitherman: I'm happy to let the deputy answer that question, but I think it's an interesting use and continued characterization of the word "bailout," especially because I think the honourable member has already acknowledged that associated with the taking on of some additional one-time costs on the province's part was some very difficult decision-making on the part of hospitals. A bailout rather surmises that you just toss a bunch of dough into the status quo with a view toward masking a problem, and that bears no resemblance whatsoever to the strategy that we've employed. We did acknowledge toward the end of the fiscal year that hospitals that were in a situation where they were taking action to have their budgets in balance might require some one-time assistance to address one-time costs. We thought it was appropriate to support that. By all accounts, I think it's inappropriate to support that. By all accounts, I think it's inappropriate to characterize that as a bailout. But the deputy will give you some of those numbers.

The Vice-Chair: Are you satisfied with the answer?

Mrs. Witmer: No, I would like the information, actually, from the deputy.

Mr. Sapsford: Mr. Chair, the difference is at a level of $200 million.

Mrs. Witmer: Two hundred million?

Mr. Sapsford: Yes. Of that, approximately $91 million was used to fund labour adjustment strategies.

Mrs. Witmer: Can you explain what you mean by "labour adjustment strategies"?

Mr. Sapsford: It could have been a bridging to retain employment. It could have been used as part of a severance, where that was necessary. These would be one-time related costs.

Mrs. Witmer: Is that the amount of money that was given to the hospitals when they laid off the nurses?

Mr. Sapsford: Well, I can't break it down.

Mrs. Witmer: Because that was $91 million.

Mr. Sapsford: That $91 million was related to labour adjustment.

Mrs. Witmer: So that well could be the case, then, that hospitals were given $91 million when the minister announced that nurses were going to be laid off. The figure is the same, I guess.

Mr. Sapsford: What I can't do for you is to relate one number directly to the other, but it would be used for severance arrangements in cases where staff were laid off.

Mrs. Witmer: That's right.

Mr. Sapsford: Or training was the other one-time expenditure—retraining. Positions may have left one department, but opportunities were created. Staff that needed retraining to take on those positions would be part of these numbers. Ten million was allocated to small hospitals for their particular issues, and another $89 million was provided for efficient hospitals. Those three together were the $200 million.

Mrs. Witmer: And that's all that hospitals have received since January 17, 2005?

Mr. Sapsford: That's my understanding. Well, there may have been capital equipment money—I'm just not sure of the timing—but against operating costs, that would be the amounts.

Mrs. Witmer: I find it interesting that $91 million seems to correspond with the amount that was allocated so we could lay off almost 800 nurses.

I want to go back to this construction of hospitals and additions. There's a hospital in our province that we know has some very serious health and safety issues, and that hospital is Mattawa General. It is about 65 miles from North Bay. As you know, there was approval for the project from Minister Clement in 2001, and the request to tender was submitted in 2004. Minister, when are you going to be giving approval for that hospital to proceed with its project? Because the consequences of not doing so pose some very, very serious—I can't stress it enough—health and safety issues.

Hon. Mr. Smitherman: I think we've gone over this ground pretty effectively earlier today: another Tony Clement announcement that you say had approval. But the problem is that I suppose an unfunded—I don't know how you characterize an unfunded approval. We have to remember the context here, and the context is clear. Your party brought forward a budget in 2003 that you claimed was in balance, but the former Provincial Auditor has proven that it was not, to the tune of $5.6 billion, which, by the way, didn't even capture some of your unpaid expenses buried in the working capital deficit challenges that hospitals face. So the circumstance we have is very similar on the capital side, which is that in the run-up to the last election and through a series of other things we spoke about, Ontario ends up in a circumstance with more hospitals committed than resources to be able to move forward at the same time.

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I'm not in a position to discuss the issue of Mattawa, because I don't have its circumstances fully in mind, except to say that in each case where a hospital has developed a plan, we seek to create the opportunity to move that hospital forward. Mattawa's circumstances are there, but I think they are not entirely unique. I would note in that same area, a hospital long promised by your party and by your former Premier, who came from that riding, was in fact delivered by Monique Smith, my parliamentary assistant, which I think stands as very apt demonstration to the people of northeastern Ontario of the commitment we make, particularly when you consider the work we've had to do as well to mop up after some pretty poor handling by your government of the situation in Sudbury. Northeastern Ontario is a place where a significant amount of hospital resource allocation are ongoing, but I acknowledge that across the breadth of the province, there are many, many projects that still warrant additional support, and considerable additional support will be forthcoming.

Mrs. Witmer: If you want to talk about North Bay, the day of the announcement, my leader had been up in North Bay and obviously was quite concerned, as were the people of that community, that the hospital announcement had not been made. Interestingly enough, the opportunity was presented, I think, in a very makeshift manner, and an announcement was made because of the pressure that John Tory put on the government to make this announcement.

Hon. Mr. Smitherman: Where's he going next, so I can get ready?

Mrs. Witmer: He's going to Cambridge, so we expect an announcement any time, and then up to Mattawa.

Hon. Mr. Smitherman: I'll get ready to wilt.

Mrs. Witmer: Anyway, if you want to talk about the budget, you and I both know that no audit whatsoever was done and you did inflate the numbers. You added in some hydro charges and everything else you could to make the numbers look as high as possible. We indicated how you could balance the budget, and your government chose not to. I don't think we even want to go there.

However, I would like to ask you right now if the CCACs have received their allocations for this year.

Hon. Mr. Smitherman: Deputy?

Mr. Sapsford: Yes, they did go out.

Mrs. Witmer: What increase were they provided with?

Hon. Mr. Smitherman: We'll get you that number in one second.

Mr. Sapsford: Did you want to carry on?

Mrs. Witmer: I will. I'd be interested in seeing the OHIP numbers. What is the government presently paying as far as the fee-for-service dollar allocation?

Mr. Sapsford: For the CCACs, the increase, year over year, was 11.9%.

Mrs. Witmer: That increase was intended to do what?

Hon. Mr. Smitherman: Provide support for an additional 45,000 acute care clients. The federal accord that governs these dollars, I believe, also includes resources—correct me if I'm wrong on any of this, Maureen. Is end of life wrapped up in that number?

Interjection: No. It's separate.

Hon. Mr. Smitherman: Expanding service to 45,000 additional acute clients.

Mrs. Witmer: Does this also allow the CCACs to pick up the slack, now that hospitals are being placed in a position where they must balance their budgets and they're being forced to divest, as you know, some of their program services—day programs? It's great to talk about breaking down the silos, but I guess what we need to make sure of is that people are not being totally ignored and forgotten as some of these services are no longer provided at the hospital.

Hon. Mr. Smitherman: The combination of these enhancements to CCAC services and the other enhancements across the breadth of our community portfolio—as an example, I think that Hilary Short, from the Ontario Hospital Association, has acknowledged the complementary nature of investments. The fact that the 45,000 additional clients being served had associated with them the word "acute" was an acknowledgement that each of those services was designed to take some pressure off hospitals.

The short answer is yes, not only in that area but also through other investments we've made, including our contribution to community support services, designed to keep people healthy in their homes longer, and also work around some of the resources we've brought to bear on files like mental health. We know that lots of people in need of community-based mental health, if they get it, will be prevented from an acute mental health occurrence. It's another example of taking pressure off the hospitals.

Mrs. Witmer: I have to say that we, as you know, put in place those community programs, and I was pleased to see that further announcements continue to be made. In fact, last week I was congratulated for what we had started to put in place and what is being continued. I support doing everything we can to keep those people there.

Do you have the number yet for the fee-for-service allocation?

Mr. Sapsford: Yes. The increase over printed supplementary estimates is $342.8 million in this estimate related to the Ontario health insurance plan.

Mrs. Witmer: Where would that increase primarily be directed?

Mr. Sapsford: A good portion of it would be related to increased utilization, so increased visits to physicians. The other portion would relate to the new agreement with the Ontario Medical Association.

Mrs. Witmer: Do we know how many more physicians we have in the province today compared to, say, 10 years ago?

Mr. Sapsford: I can't give you 10 years ago. We're probably still down, but in the last two years there have been some marginal increases in the total number of physicians. I think the increase in the last two years has been about 600 or 700. That was preceded by a number of years where there was actually a downward trend. So there has been a change in the last two years.

Mrs. Witmer: We know that when it comes to physicians, that shortage continues to be there. We also know that there are those who are receiving their training abroad. In particular, there's a large group of people in Ireland. I think the minister said at one time that those young people certainly would have the opportunity to be embraced and given the opportunity to practise here. I would like to know how many of those people who are graduating who have trained abroad are within our system this year.

Hon. Mr. Smitherman: I would say that the deputy may be able to give a number.

Firstly, on the issue of foreign-trained doctors, we also have many in our midst who were not Ontarians originally but have chosen to make their home here. Accordingly, we've sought to increase access for them to the residency and support they require to be out there in support of Ontarians.

On the question you asked with respect to Ireland—and Ireland stands as one example—we are working with IMG Ontario to increase access to residency spots for Canadians who go abroad in search of education in other places. This is a newer initiative. It would hardly be reflected to date in our statistics as this is a new move in policy that we've made, but in the forthcoming years it should enhance our capacity to utilize all the spots that are available for international medical graduates.

Mrs. Witmer: I guess what I'm hearing is that at the present time there are none of these Canadian-trained graduates in our system.

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Hon. Mr. Smitherman: Yes, there are, but I'm working on a 2004 number and, at that time, it was five. The point is that it's getting rolling in the sense that there's an annual shot at getting in. So it's something that we've just made more available. In a certain sense, it stands as an area where we can enhance our performance going forward as we've made a new policy decision, so this number will be growing.

Mrs. Witmer: So what are the future plans that are in place that would enable these young people to practise here in the province of Ontario, and how rapidly do you see that number—five—increasing?

Hon. Mr. Smitherman: I think the opportunity is that we have to get our openings to coincide with the writing

of tests. We have to be synchronized. At the time the policy decision was taken, it really wasn't practical for very many people to take advantage of it. That will be enhanced. I can't speak to a specific number, because it would be inappropriate to do so. As you well know, the decisions around who is able to access those positions is something that is taken with lots of involvement from representatives from the various medical schools in Ontario. We're going to continue to depend upon them to assist us in that way. The 200 spots that are available, of course, are ones that represent a very significant increase over the number of similar spots that were available when we first came to office, and this stands as one of five or six initiatives that we're working on to enhance physician supply overall.

I mentioned before that we're increasing the size of our medical schools. Of course, we've recently had the privilege of opening the new medical school in northern Ontario. We've worked to enhance the proportion of spots that are available for family residency. Then we work on models like family health teams, which actually provide the opportunity for more people to be engaged in care, because doctors, working along with other health care providers, can handle, if you will, through a broader circle of care, a broader number of patients.

I think that all of these things, taken together, are going to make a discernible difference to those Ontarians who are having difficulty accessing that kind of primary care.

The Vice-Chair: Thank you very much, Minister. That ends the time for the opposition. The Chair recognizes Ms. Martel.

Ms. Martel: Thank you, Mr. Chair.

I'm interested in the long-term-care funding announcements from the perspective of how they are meeting the government's commitments to residents and their families in the last election, a promise that was "to invest in better nursing home care, providing an additional $6,000 in care for every resident." I believe there is a significant gap between what the government has announced in long-term-care funding and how much of that money is actually going into additional care for residents. I don't think I'm the only one who has raised that concern.

I point to a submission that was made by Donna Rubin on behalf of the Ontario Association of Non-Profit Homes and Services for Seniors to the standing committee on finance and economic affairs in January, where she said, and I'll just read this into the record:

"The much-publicized figure coming out of the 2004 provincial budget of $191 million to support residents in long-term-care homes has been repeatedly challenged by opposition parties in the Legislature, and it was in fact acknowledged by the Premier that $75 million of this amount is for additional services to assist patients to move out of hospitals and into long-term-care facilities, for the public reporting system and Web site, and to enhance care standards, including staff and training. These are all very important and worthy initiatives, but the reality is that in the end, approximately $110 million of the $191 million was actually added to the base budgets of long-term-care homes to increase care and services for residents, rising to $116 million in 2005."

The ministry continues to use a figure of $191 million, providing the impression to the public that this is $191 million that has gone into residents' care. Because the ministry continues to do that, even in the face of comments from people who are involved in the sector, I put in a freedom-of-information request to the ministry on June 16 and asked for a breakdown of how the $191 million was allocated to long-term-care homes. In July, I was told by the ministry that I had two options to access this information: I could get it on an Excel file, which would contain all the homes and all their allocations, or I could obtain 600 ADM letters and funding schedules, four pages addressed to each home, which contained the funding allocations.

We e-mailed to the ministry on July 11 that I would like the Excel document, because I wasn't very interested in 600 times four pages from the ADM, much as they might be interesting.

I've got to tell you, Minister, that, despite repeated phone conversations with your staff, today, September 27, I still have neither an Excel document nor 2,400 pages from an ADM. I have no indication of what the breakdown was of that $191 million. I know that $116 million was posted on the ministry Web site last October. There was a breakdown of the allocations that went to each home. I don't have the rest of the information, and I honestly don't understand why it has taken this long to get, especially when I was presented with some options for that information in July. So, can you tell me what this breakdown actually is?

Hon. Mr. Smitherman: Sure. The $116 million is designed to address our goal of enhancing care through bringing additional staff into the long-term-care sector. We've had an opportunity this morning to discuss the progress that's being made toward those goals.

In addition to that, there are a wide variety of other care initiatives that have been developed, all of which have, associated with them, enhancements to the quality of care for our residents through things like education and training and the development of more best-practice guidelines and those sorts of things that allow us to make sure that policies that are developed well in one place are advanced. This includes specialized geriatric services and more work on developing common assessment projects for long-term-care residents in a variety of places.

The other part of it that I think you've seen some advantage of in the Sudbury community is the development of a strategy related to enhancing care and also taking pressure off of the acute care system at the same time through the development of alternate level of care strategies that have seen the opening of interim long-term-care and convalescent care beds.

I think that these three things, taken together, achieve the $191-million investment, and all stand as good signals of enhanced care for residents in the province of Ontario.

Ms. Martel: I'd like the breakdown of the balance of $75 million. I know where $116 million went; it's the $75 million that I have—

Hon. Mr. Smitherman: The alternate level of care aspect is $46.6 million, and other initiatives, which include internship positions for nurses, strategies to support senior nurses, development and dissemination of nursing and other best practice guidelines etc., total just over $28 million.

Ms. Martel: If I look at the $46 million and the need to put that in because of the pressures at the hospital, there is no argument from me and I don't think that there are arguments from those in the sector that that is needed to take off the pressure in the hospitals. My concern is the government applying that as part of its commitment of $6,000 of additional care for every resident. It is true that some of that money will help a particular individual who's going to go either back to their home or somewhere else in the community, but it surely can't be part of the overall enhancement that the government is making so that, as part of your promise, every resident is going to receive an additional $6,000 of care.

Hon. Mr. Smitherman: If I look at our campaign file—at no point, through the work we've done on the $191 million—I haven't been tying this back to a number; you are. We characterize the investment as an investment in enhanced care for people in the long-term-care sector, and I think that's entirely consistent with the way we've spent and allocated those resources. There's no doubt that each of these dollars spent has, at its heart, the desire to enhance the quality of care for residents in that sector. We've obviously been clear in characterizing $116 million as what is necessary to enhance by 2,000 the number of people working in the long-term-care sector, with a view toward ensuring that at least 600 of those are nurses. We continue to work away on demonstrating the achievement of those numbers, but all of the $191 million has gone toward enhanced care in what is appropriately called the long-term-care sector. How that's accounted for beyond that has not really been the way that I have been choosing to communicate.

I think that it's also important to note that we made other commitments. I'm very, very proud that our government has come within pennies of achieving a commitment to reverse the increase in the co-pay that the Conservatives brought in and also to make the first increase in a heck of a long time in the comfort allowance. These things, taken together, obviously all represent important steps in our government's commitment to enhance care in long-term-care homes.

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Ms. Martel: What do you characterize as money that's being contributed to, as per the election promise, the additional $6,000 in care for every resident? Of the allocations that you are making in the long-term-care sector, which of those go toward fulfilling that commitment to get to the $6,000?

Hon. Mr. Smitherman: If I read my party's campaign platform, that number is not there. Maybe that is from a piece of correspondence or something. I'm really measuring it more on the basis of, what progress are we making toward our commitment to enhance the quality of care in the long-term-care sector? I characterize every penny of this $191 million, and some other dollars as well, as progress toward improving the quality of care, but we haven't sought to view this simply as a discussion with respect to dollars. We also view it as an opportunity to strengthen regulation and to bring in a piece of legislation that will go many steps farther. Across the breadth of all of these initiatives, there are obviously monetary gains and improvements that have been made to address care, but we've also viewed it as necessary to move forward in a complementary fashion around regulation and legislation. As I had a chance to say in my opening speech, legislation will be forthcoming later this year in that regard.

Ms. Martel: The $6,000 comes out of campaign literature from a Liberal candidate, so I take it as an election promise, and I also take it that when people saw it, they made decisions about voting perhaps solely on that issue, that their mom, their dad or they themselves, as a resident in a long-term-care home, were going to benefit by the election of a Liberal government to the tune of an additional $6,000 of care, not only for themselves but for every resident in a long-term-care home. Why I'm asking this question is to get at where the government is in terms of the commitment it made for an additional $6,000 per resident, for every resident in a home in the province.

Hon. Mr. Smitherman: The evidence is there. For anyone who is in a situation where they are in a home or they're attending or related to someone who is in a home, the evidence abounds around the commitment our government has made to improve the quality of care in those homes, to answer the first part of your question.

I don't think you have a piece of literature from me with that figure in it; I don't know. What I know for sure is that our party platform did not have a figure like that in it. But like I said, I'm not involved in that exercise around a certain number of dollars that you're speaking about. I can tell you that as the Minister of Health in Ontario, I've had the opportunity now over almost two years to invest a considerable amount of time, energy and resource, and quite a lot of fiscal resource—that is, the money of the people of the province of Ontario—to enhance the quality of care for our loved ones who are living in long-term care.

To your question about election strategy and the like, we'll be held accountable at election time. I feel quite confident that people will see the progress we've made in long-term care. I'm the first to acknowledge that, as in almost every other area of health care, there is more work that can be done. Not all governments have felt inclined to do so, but we operate within an environment of some limitation of fiscal resource, and within that we've made a very, very strong commitment to long-term care, both by putting more dollars into the system that we had and by extending the capacity of the system both in terms of

new beds and new interim beds, which have the positive benefit of also assisting our hospitals.

Ms. Martel: If I might, let me read into the record, then, information from a press release that was put out July 18, 2005, by the Ontario Association of Non-Profit Homes and Services for Seniors. It says the following:

"During the last election, the Liberals pledged to raise annual funding for homes by $6,000 per resident, or by $450 million a year. The Liberals acknowledged that this was the amount needed to ensure an appropriate level of care after years of funding neglect.

"But after two provincial budgets, they are less than a third of the way to their commitment. The total increase in funding per resident is little more than $2,000."

Would that be a correct assumption on the part of the Ontario Association of Non-Profit Homes and Services for Seniors?

Hon. Mr. Smitherman: No, it wouldn't, for two reasons; firstly because of this reference in their press release to "the Liberals." If you look at the Liberal Party campaign platform, there is no reference to $6,000. And on the issue of their calculation, I think they have decided not to take into consideration the amount of resource that the government has taken unto itself to pay in terms of progress toward the commitment we made on eliminating the co-pay. So there are many dollars that they are well aware of that they're not taking into consideration. I reject overall the calculation that they're working on.

What I know for sure and what I'll be able to tell my constituents, what my colleagues will be in a position to tell their constituents and what you'll be in a position to tell your constituents, is that the long-term care sector in the province of Ontario is receiving tremendous new resource to address issues that we share a concern around in terms of the quality of service being provided there. But it's not only about money. The initiatives that we've undertaken are also about improving accountability and helping to change the culture in these long-term care homes with a view toward ensuring that our most vulnerable Ontarians are receiving the care, support and love that they require to thrive to the best of their capacities. We're going to continue to dedicate ourselves to that, and I'm proud of the progress that we're making.

Ms. Martel: OK. But I go back to the point that this was in a campaign leaflet put out by a Liberal candidate. I have to assume that that was an election promise by the Liberals unless someone was freewheeling on their own, which I doubt.

Hon. Mr. Smitherman: Does that not happen in your party? It happens in my party.

Ms. Martel: I doubt that someone would freelance and say, "$6,000," without having a problem with the Liberal Party and being a candidate. I highly doubt that.

You talked about co-payment. I think that neither the Ontario Long-Term Care Association nor OANHSS would consider the essentially inflationary amount that is being covered through the co-payment as increasing direct care to seniors. That essentially was the promise you made, that it would be $6,000 in additional care for every resident. Paying the inflationary portion of the co-payment isn't going to add a single body in a long-term care home to provide additional care. Alternately, paying the tax portion of long-term care facilities back to municipalities is again not going to provide additional care to those residents who were promised $6,000 worth of additional care.

Let me get a comment from you for this fiscal year, because an announcement of about $28 million was made in money that goes to the per diem for long-term care homes—so actually into an allocation for increased nursing services. Where is the balance of the $264 million in long-term care that was announced in the budget? What makes up the difference between the $28 million that will go into additional care and the balance of money that's been announced in this budget?

Hon. Mr. Smitherman: The deputy can provide you with more detail on that. That's obviously about our ongoing commitment to seniors in the form of expanding the long-term care sector. But unlike you, I kind of figure it out like this: If I'm in a long-term care home and all of the sudden increases that in every other year in every other environment I've paid are rolled back—in other words, I'm not asked to pay them, even acknowledging that there is inflation in those environments, and instead the government steps in and takes that cost onto themselves, and therefore my pocketbook is freed by that amount of money—I'm going to consider that as an opportunity to enhance my quality of life.

Ms. Martel: How does that take in additional care? Am I going to go purchase their additional care now with that money?

Hon. Mr. Smitherman: Maybe a quality of life measurement for someone is the ability to give their grandson a Christmas present that they hadn't been able to afford over a longer period of time.

Ms. Martel: But it's about the promise that you made for additional care, Minister, not about Christmas presents. Come on.

Hon. Mr. Smitherman: Again, I'm pretty sure that there were NDP candidates in the last election that called upon the nationalization of income, and some people in your party might have left that behind.

But you're using a campaign leaflet. Our party's platform did not talk about $6,000. So you and Donna Rubin's insistence on it aside, the reality is clear and it's the same. If you're in a long-term care home in the province of Ontario today, you're receiving a better quality resource and support than you were when our government came to office.

But we're not done yet. We have more work to do. Some of that is legislative, some of it is regulatory that falls out from that and some of it is about what we seek to do to enhance the culture and the quality of care that's provided there. At the time of the next election, people will hold us accountable on those things, and I'm quite certain that, based on the progress that we've made so far at improving the quality within the existing sector and by enhancing access by putting more beds in place, people will recognize that as a government we've moved for-

ward in a fashion which recognizes the complementary nature of health care services, and that long-term care has been enhanced and broadened.

Ms. Martel: Let me go back to the breakdown, which I'd like to get from the deputy. Let me go to a very specific election promise that was also made by Dalton McGuinty that has to do with reinstating the levels of care. Previously, under our government, there were at least 2.25 hours of hands-on nursing care in regulation. That was cancelled by the Conservatives. Before the election, your Premier wrote to SEIU and promised that, if elected, the Liberals would reinstate the 2.25 hours of hands-on nursing care to ensure that residents would get the quality of care they need. Can you tell me why your government still has not reinstated the minimum 2.25 hours of hands-on care that was promised, let alone increasing the level of care, given the need by so many residents and so many facilities?

Hon. Mr. Smitherman: I think two points bear repeating. The first is that, as a government, we have moved forward to re-regulate, if I could use that phrase, some minimum standards. Progress has been made on those points, which is widely acknowledged. And there is not entirely a consensus on the point with respect to telling front-line health care providers, whom we ask every single day to exercise judgment on our behalf, what kind of hourly allotment is necessary.

The whole case mix index that we spoke about before is designed to reflect the nature and acuity of people's circumstance. Associated with that and the management and the professionalism of those people who administer our long-term-care homes, is the expectation—you can pretend to be able to micromanage everything from head office but the reality is that on the front lines in health care delivery, we have extraordinarily well-informed, well-educated and well-intended people delivering care. We've made important progress toward these minimum standards but we also have a lot of confidence that those people who are on the front lines of health care are exercising good quality judgment and are seeking to provide the best quality of care possible to the people who are in those environments. So we've made good progress there, but, like I said a couple of times already, there are lots of areas where we can identify opportunities for more improvement.

Our mandate is but half done. I remain confident that by the time the next election comes around, people who are looking at long-term care, as you've said on a single-issue basis, will recognize that our government has substantially made progress in a wide variety of areas. Like everything else in health care, there will always be opportunities to do more.

The Vice-Chair: The time has expended. We will now move—

Hon. Mr. Smitherman: Mr. Chair, could I beg your indulgence for another one of my short little runs down the hall.

The Vice-Chair: The Chair recognizes the government side and you can take time. We're going to have a couple of minutes of recess here.

The committee recessed from 1512 to 1515.

The Vice-Chair: We're back in session. I have sort of an administrative question that's been brought forward by Ms. Martel, if you'd like to address that concern.

Ms. Martel: Thanks, Mr. Chair. I appreciate the indulgence of the committee.

I understand the committee is scheduled to finish at 4 today. I am just asking whether people might be in a position to sit longer. My request is because, as a health critic, I was due to sit in the committee hearings tomorrow for Bill 101, which is on newborn screening, and that's due to start at 9:30. We will have about three hours still to go tomorrow, which is causing a bit of a problem in terms of scheduling for me to be in that committee or to get someone into that committee. I understand that even if we go till 5, that will only take out another hour and we will still have two, but if we start at 9, I can get most of my questions done. I just put that out. I know people are busy and maybe have an expectation to finish at 4, but I don't know if there's any appetite to sit a bit longer or not.

The Vice-Chair: Are there questions or comments on the suggestion by Ms. Martel that we sit till 5 today, which would advance the whole thing?

Ms. Di Cocco: I understand. It's just that it's been a long day, and we knew what the time was. That's my response: It's been a long day.

The Vice-Chair: Any further comments?

Mrs. Witmer: I can certainly appreciate the dilemma being faced by Ms. Martel, and I would certainly be pleased to sit longer if that's going to help them deal with the situation that she's just explained.

Ms. Di Cocco: The time has been stated, and it was made clear to me that there was little appetite to make any changes in the times allocated.

The Vice-Chair: Very good. Is there any further debate?

Ms. Martel: I didn't realize it was going to be such a problem. I think we've been pretty good to give the minister some leeway here today. I'm not suggesting that it's an hour, by any stretch, George, so you don't have to look like that.

Hon. Mr. Smitherman: I don't know what leeway—because I went to the washroom?

Ms. Martel: There's been more than one break here today, which has been fine with me.

Hon. Mr. Smitherman: For goodness' sake.

Ms. Martel: I'm not suggesting for a moment that that has taken an hour or that we should do a tit for tat. For goodness' sake, I'm trying to sort out a scheduling problem because the committee this morning started later than we were supposed to. It did.

Hon. Mr. Smitherman: As a non-member, is it appropriate to speak, Mr. Chair?

The Vice-Chair: No, it isn't, actually. The committee members are discussing it.

Is there further debate? If not, I'll call the question on whether or not we extend hearings today for an additional hour.

Ms. Martel: I didn't put it as a motion; I just asked. That's fine, Mr. Chair, don't worry.

The Vice-Chair: It sounds to me, with the will of the committee, that the majority does not feel it's appropriate that we extend the hearings for an additional hour today.

I recognize Ms. Di Cocco.

Ms. Di Cocco: Thank you, Chair. One of the probably interesting aspects of the transformation of health care is the local health integrated network that is evolving. In the discussion of how we are going to use this geographic governance model that is being created, there are questions, certainly, that have been posed to me about the notion of being able to—we have a referral centre in Sarnia that goes to London, and there's a constant questioning or interpretation of this local health integrated network being a containment of health care. I'd really like clarification. My understanding has been that this is a governance model that is going to have many different responsibilities. That is one aspect of my question, about the role of this geographic area.

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The other one is if it will have a role in evolving or changing what I perceive and has been perceived to be a fragmentation of health care delivery that we have in the system. It's those two aspects.

Hon. Mr. Smitherman: If I don't nail the first part of your question well, I hope that you'll rephrase it. I think I got a sense of where you're coming from. I had the privilege of being in your community shortly after I was named Minister of Health. We had that big round table. I remember lots about it, but the thing that I took away more than anything else was the hardship that's being faced by people in Sarnia who are travelling to that referral centre because they're diabetic, and that the absence of satellite dialysis services in Sarnia stands as a hardship.

I believe that local health integration networks and the capacity to actually collect data that links up to a set of patients is going to create a strong argument not just for what services need to be created in local communities but, over time, for some of those services which might have accumulated, if I could use that word, at these larger centres, that I think we might actually be engaged in a debate that looks for opportunities for some of those to be repatriated to local communities. I actually think that the local health integration network is going to assist the people in Sarnia, in your area as an example, to make a stronger case for those inadequacies that are existing around health care.

On the containment piece—I'm not sure this is what you were getting at, but let me just say this: I try to say, in the story with my mom, that these are not impenetrable boundaries for patients. What we seek to do is create a discussion within these established boundaries, looking at the patients and the population health of the patients to say, "How are we doing at meeting the needs of the patients in those areas, and how can we do better?" As part of that may come the conversation to say, "You know what? There's enough need demonstrated here in Sarnia to have these services provided in Sarnia, and perhaps some of that capacity is to be found in other places where they're already travelling to get those services." That's the best way that I could answer that, I think.

You used the word "fragmentation." I hear the word "fragmentation" used most often in the health care context as it relates to the fragmentation in delivery of community-based mental health services. I use my own riding as an example, the place where we sit today. Toronto Centre–Rosedale is a pretty dynamic place, and there are a lot of social services being provided there, and there are a lot of people with underlying needs. There are dozens and dozens of community-based mental health and addiction organizations in my riding, funded by the same Ministry of Health and Long-Term Care. There has been no dynamic to date—none whatsoever—to bring those health care providers that are operating in the same geographic area, probably in some cases in the same street, to come together and say, "Who are you serving? Who are we failing to serve? What gaps exist, and what could we do better to coordinate our services in a fashion that addressed those gaps?"

Some people get tired of the idea that we can do better with the same resources that we have. The more I'm around this place, the longer I have the privilege of holding this role, the more what I call low-hanging fruit I see, like the stories that I told you before about the MRI. When we asked the right questions, we found that there were MRI services that are not being operated appropriately, efficiently, in our province. Similarly, I'm quite convinced that if we create the dynamic, the table, if you will, where a new kind of conversation takes place that involves health care providers and population health-based information, we will create a very strong dynamic that can address some of the fragmentation that occurs.

Maybe it sounds overly simplistic when I celebrate the idea that local health integration networks are already powerful because they create a new story in the newspaper, a new way of telling the health care story, or because initial time is being spent by the leaders of these local health integration networks meeting with health care providers, and this sounds to some people like I'm trying to make something to be more than it really is. But I think it's fundamental to the culture that we're seeking to create, which is a new kind of discussion and conversation and one where people from the local area closer to the action are there, helping to make really hard decisions but with their local patient base and health care providers in mind.

The Vice-Chair: Dr. Qaadri.

Mr. Qaadri: Minister, I'd like to ask you a question and ask if you might be able to share your vision on a problematic area that I encounter on a regular basis, and that is, of course, internationally trained medical graduates.

As a graduate of the University of Toronto medical school myself, I'm relatively sheltered from this particular area, but nevertheless, constituents I interact with,

both in riding and out of riding, often bring the plight of IMGs—international medical graduates—to my attention.

What I'm asking is, would you be able to please summarize, in a hopeful manner, your vision and the direction of this government: what is it we inherited, where are we now, and what does the future hold? Of course, in this question, no doubt you'll have to touch on numbers, examinations, placement, the effects on the overall health care system, and so on. But I would, with respect, ask that you not take refuge in acronym-laden bureaucratese or mere numbers, but actually outline your vision. The reason I do this is because I would like you today, for this committee and others, to empower me personally and also Ontarians on this file.

Hon. Mr. Smitherman: Well, you take away my use of acronyms and I'm pretty much useless.

Here's the way that I answer your question. I'm going to pick up on your use of the word "vision" at the front end. A few things: Let me try to connect them well. Firstly, let's acknowledge something that doesn't get acknowledged every day: 25% of all the doctors practising in Ontario are foreign-trained doctors. Go to any community; they're there. They're very prevalent, as an example, in Sudbury.

Part of the difficulty that we have on this issue, maybe the most candid observation I can offer and one that I don't think is ever going to go away, is that I believe it is always going to be possible for the news media to tell a story of a foreign-trained doctor who meets barriers that they cannot overcome to practise in our province. So the much-trotted-out story of the pizza driver and the taxi driver I doubt very much is ever going to go away. That is because we need to acknowledge that, while there's much more that we can do, there will be circumstances in our province where people who have received their medical education in other places cannot satisfactorily achieve the very high standard that we have in our province. Nobody wants to see any watering down of those very high standards, but at the same time there's a great degree of sympathy for the idea that people are being left on the shelf when they could be providing service. That balancing act is a very difficult one.

We sought, as a government, to do a variety of things to ease the flow, if you will, of international medical graduates to practise. We've more than doubled the number of spots available, and today in Ontario we have made quite a lot of progress. If you look at what we're doing versus other jurisdictions in the country, we're doing an awesome job, notwithstanding the fact that it's still fraught with challenges for many individuals. We've more than doubled those opportunities, and that's allowing the production line to grow and for more of these doctors of tomorrow to make progress that way.

The other thing that we're finding is that, of those who meet with success in being able to access these residency spots, many are requiring a greater degree of training and upgrading than would have been anticipated at the front end.

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So I give you some sense of the challenge that we're facing, but the underlying message that I would send is this: We have quite dramatically increased our access. We're benefiting tremendously already from the contribution that foreign-trained professionals and foreign-trained doctors are making. We have an untapped resource that we have not yet fully taken advantage of, and we have much more work to do in terms of further analysis and streamlining of our process so as to reduce barriers wherever we can.

Then we have another obligation too. Depending upon their age and the amount of additional training required for some and the necessity of more immediate income-generating opportunities, some people will choose to or be forced to consider other options. One of the things that we have done, with the Ministry of Training, Colleges and Universities, is create bridging programs to other health professions and also create a program to assist people in improving some of their standards around language, as an example, which also proved to be a barrier.

All these things taken together mean to me that we have a very positive outlook. We're providing new opportunities for more people all of the time, but we will continue to struggle against the storyline, because not all of those foreign-trained doctors who have been granted the right to practise in other environments are going to be able to make it through, from the standpoint of their time or their capacities, all of the filters, if you will, that are there before we send someone out to the critically important work of providing direct patient care.

The Vice-Chair: Mr. Milloy?

Mr. Milloy: I only have a few minutes, so I'll be very quick. My last question was very community-specific, and now I'm going to go to a more general question about health care as a whole. The recent Supreme Court decision dealt, obviously, with a specific situation in Quebec, but has been interpreted as possibly undermining health care as we know it and creating a two-tier system. You touched on it briefly in your opening remarks, but if you could respond as to how Ontario is dealing with this ruling and will deal with it as it moves forward.

Hon. Mr. Smitherman: Let me say two things and then say a bunch more.

The first thing I want to say is that our government's commitment to medicare is well established in our bill the Commitment to the Future of Medicare Act. We remain committed to the view that Ontario and Ontarians are well served by a universally accessible, publicly funded system of health care.

It's a bit counterintuitive, but the word that I return to most often related to the Chaoulli decision is "validation." This decision started as a case seven years ago about a hip, or, more to the point, about the inability of a public system in Quebec to deliver that hip in a timely enough fashion, therefore leading the person who needed it replaced to say, "It's inappropriate to prohibit me to purchase insurance for a service that you're not providing in a timely way." This is a Quebec dynamic.

The reason I use the word "validation" is that it is very important to acknowledge that this is Ontario and not Quebec. We ran on a commitment to reduce wait times, hips and knees being one of those places where we focus our time and energy. Accordingly, we've been putting additional resource into the health care system to address one of these challenges, which we know is going to get worse as the population ages.

There's no doubt that the Chaoulli decision has inflamed the debate, and it has offered, if you will, the opportunity for those who view more private care as the panacea to put up their hands and say, "Me too." But I don't think it has done so much to inform the debate in a way that gives us any new solutions. Private delivery of health care in a universally accessible environment is nothing new. In the province of Ontario, something like around 30% of the care that we deliver is delivered that way. Many of the elements of the health care system that perform, at least on anecdotal testing that I do with people, perform well. An example would be a breadth of diagnostics around independent health facilities or a lot of the lab work that we do. There is already a broad amount of private, for-profit care that is delivering universally accessible benefits.

We don't see it as a panacea, but we see the storyline that's there as validation of our government's commitment to reduce wait times and to recognize that associated with the principle of public health care should be quality. In a certain sense, we're on a mission of what I call continuous quality improvement. Accountability, transparency and creating the opportunity for people to be involved in that discussion, through initiatives like public wait times and through the Ontario Health Quality Council, I think are going to be Ontario's contribution to this discussion.

The Vice-Chair: With that, we'll move to the final rotation. Each side will get eight minutes. We'll start with the opposition.

Mrs. Witmer: It's very interesting, Mr. Smitherman, to hear your comments now acknowledging that there's a lot of private health care in the system already. When our government had the courage to acknowledge that if we were going to meet the infrastructure needs of hospitals in the province, we'd set about taking a look for private funding, I can remember the fearmongering that took place. In fact, I have some quotes in here about some of the comments that you and your Premier made about these deals, and about private MRI and CT scan clinics, and how you were going to eliminate these deals. I'm glad you've seen the light and that you do acknowledge that as long as it's funded through the OHIP dollar, we need to make sure we can provide these services to people in Ontario and also build these additions and new hospitals that are so desperately needed in our communities.

I want to go back just briefly to where we started today. We've heard a lot about wait times, and certainly we haven't seen much action other than wait times. I want to remind you that not only was it our government that put the Cardiac Care Network in place, we also established the Ontario joint replacement registry in 2000 which, as you know, actually did collect data on full wait times; that is, from the initial visit to the family doctor, to the specialist, through surgery, with the goal of providing timely access to hip and knee surgery and improving patient outcomes.

The reality is—and I think that people in the province of Ontario need to be aware of this—that you have now decided to eliminate this Ontario joint replacement registry. There are many in this province who feel that you want to control the data so that you can meet whatever wait times you might put in place. I think it's important to know that the orthopaedic surgeons oppose your move, and the service providers, such as the Ontario Arthritis Society, are opposed to your decision to terminate the Ontario joint replacement registry. They've all said that valuable outcome data are going to be lost, data that are going to help reduce surgery and wait times for hip and knee by reducing revision surgeries. I think if we take a look at what you've said today and what's actually happening, there is a big gap between action and word. I hope that you will seriously consider not eliminating the Ontario joint replacement registry, which was very well supported by the provider agencies, the public and the surgeons.

My question is about what you're doing in the area of the Ontario drug programs. There's very little time. You've recently appointed Helen Stevenson to head your new drug secretariat, I understand. I don't know; I've not seen an announcement on it. I don't know who she is and nobody else seems to know who she is. I'm not sure what her operating budget is for the new drug secretariat; maybe you could tell me. Maybe you could tell me what her salary is, and also what she's going to review.

Can you also guarantee that whatever you are doing in the way of taking a look at the drug program, you will not income-test, introduce user fees or reduce access to drugs for people in Ontario. I guess that's the guarantee that people are looking for, because we're not quite sure what's going on here.

Hon. Mr. Smitherman: There are two parties in the Ontario legislature, and the Liberal Party is not one of them, that have on their record a history of reducing the amount of money available in the Ontario drug benefit. In case you haven't figured it out, your party was one of those. There's a lot there. The deputy may want to pick up on a little bit of it.

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Firstly, with respect to where you started, we improved your deals. William Osler and Royal Ottawa are both arrangements that were quite significantly improved due to our government's involvement.

To the point about MRIs and CTs, we've made quite a lot of progress at reducing wait times on these things because we've brought them together. In other words, we made sure that MRIs and CTs, no matter where they are located, are working as part of a system, and we've increased capacity by 42%. We were in a situation where

private MRI clinics—you know, an MRI is not an MRI. There's a difficulty level, if you will, that affects costs related to the kind of MRI service you're providing. There was no disincentive—in fact, there was a perverse incentive there for private providers to cherry-pick and do the easy services, leaving the more difficult ones to the public environment. We're very interested in the idea that when you have a system, when you want to use that word, they operate in a complementary fashion.

You made a very impassioned defence of the joint registry. I had the chance to meet with the orthopods and I understand the concern around loss of data. There will be no data lost; we've made that commitment. I think maybe some of your information was a month or two behind—

Mrs. Witmer: No, it's very recent.

Hon. Mr. Smitherman: —because it has been an evolving issue. But it's interesting that you've come to the defence of something that—you live in Kitchener, so maybe tomorrow you could tell me what was the waiting time for a hip in Kitchener under the joint registry that you funded. Maybe you could tell me that tomorrow.

The surgeons kept this information in their pocket. It was not information that came together all in one place. While it was very valuable information, and therefore we've made sure that we will maintain it and that it will be there for the longer term, it is not information that was made available to Ontarians or even to those people whom we pay to run our hospitals.

With respect to drugs, there can be only one observation drawn from the estimates as relates to our ministry, and that is that the government in Ontario continues to advance on the idea that it's essential that we provide appropriate drugs to people to allow them to experience the highest possible quality of life. The resource that we've put behind this I think stands as an apt demonstration of our government's commitment. Helen Stevenson is certainly there, working within the ministry to address a variety of challenges and opportunities that exist related to the drug strategy. We'll be forthcoming on more of that in the period of the next perhaps three to six months, and I look forward to being engaged in a discussion at that point with the honourable member.

I would just say that today, I think it was, or perhaps yesterday, CIHI put out data which makes a very important point to Ontarians—and I think we should be celebrating this in a certain sense—that in Ontario, we have the highest per capita support for drugs. It's quite far advanced over that in other jurisdictions and I think stands as an apt demonstration of our government's commitment to provide people with the drugs they need to sustain the highest possible quality of life.

The Vice-Chair: Thank you, minister. That's all the time. We now move to the NDP.

Ms. Martel: I'd like to get the details, if I might, of the balance of funding for long-term care this year. The budget has an announcement of about $264 million. About $28 million of that is to increase per diems in long-term-care homes. Can I ask what the balance of the funding is going to be allocated to?

Mr. Sapsford: We'll get a detailed breakdown for you tomorrow, but I can give you some of the major components of that. As you mentioned, the $28 million is related to general increases. Other amounts for pay equity, about $19 million. The annualization cost of the $191 million that you referred to earlier is also part of that increase. Then about $90.5 million is related to the opening of new beds in the system. There are some additional amounts which I'll clarify for you tomorrow, but those are the large components of it.

Ms. Martel: Thank you, Deputy. I appreciate that clarification and look forward to that information tomorrow.

Returning to the minister, with respect to the government's promise in the election to reinstate minimum hours of care, this commitment was very clear in a letter of June 11, 2003, signed by Dalton McGuinty. It was a response to a questionnaire that had been put out by the Service Employees International Union, many of whose workers work in long-term-care homes. The question was, "Will your government establish a minimum number of care hours nursing home residents must receive on a daily basis? If so, what should the number of care hours …be?" The response was, "Yes. Ontario Liberals are committed to reinstating the standards of care for nursing homes that were removed by the Harris-Eves government—including minimum 2.25 hours of nursing care daily and three baths per week." That was the promise that was made.

To date, there has been a regulation change that allows for two baths per week. There has been no regulation change that would implement standards of care. Those same workers who you talked about in the last rotation who are very much trying to provide quality care and doing the best they can are the same ones who are now saying that we should actually be having a minimum standard of care of 3.35 hours. Those workers include workers represented by ONA, SEIU and CUPE.

I would ask again, is it the intention of your government to live up to the election promise and reinstitute a minimum standard of care, and what would that minimum standard be?

Hon. Mr. Smitherman: Hansard will reflect that I've already given a fulsome answer on that question. I don't want to belabour people's time by repeating it all. It's there in the last rotation.

Ms. Martel: Maybe I'll just ask it a different way. Is it your intention as a government to reinstate minimum hours of care in long-term-care homes? Yes or no?

Hon. Mr. Smitherman: I already told you that we've made considerable progress on improving the quality of care for residents in long-term care. Associated with that has been the adoption of minimum standards in some areas. I'm the first to acknowledge that there's more progress to be made around those things, but I'm not in a position as it relates to my estimates today to be able to give further indication of where and when that will be forthcoming.

Ms. Martel: Can I ask when you will be in a position to give an indication?

Hon. Mr. Smitherman: Perhaps at estimates next year.

Ms. Martel: It sounds to me like you're not really interested in living up to that election promise, Minister. That's the only conclusion I can draw from your answer.

Hon. Mr. Smitherman: You can draw your conclusion. Substantially, Ontarians will be in a position to draw a conclusion; that is, that our government's commitment to the quality of life for those living in long-term care has been dramatically improved as a result of our coming to office. That is reflected across the breadth of the work we've done through Monique Smith's report, to work we've done to improve the culture in long-term care, the minimum standards we had begun to reinstate and the clear investment we made to bring more than 2,000 additional employees to the provision of service for these very same residents.

If you want to keep asking these questions in a political or electoral context, I give you this assurance: As I stand here nearing the mid-term point in our government's first mandate, I remain very confident that as we go to the electorate, long-term care will be one of those things that we very proudly talk about in terms of the commitments and the improvements we've made, while acknowledging that across the breadth of health care there are always opportunities to do more, but we are operating in an environment where we've got to consider a wide variety of priorities. I think Ontarians will appreciate that we've made investments across the breadth of health care, recognizing the interdependent nature of a variety of these services.

Ms. Martel: I would just conclude on that point by saying it's interesting, Minister, that two of the three regulations you said you would reinstate you have; the third with respect to minimum standards of care remains outstanding.

Just on the issue of quality and improvements made, I have a copy of a letter that was brought to my attention. It was given to one of your colleagues, Mr. Parsons, MPP, on August 26, with respect to the change in the number of baths per week. I found it particularly worrisome and I wonder if he's brought it to your attention. I'll just quote the relevant section. It was from the Service Employees International Union and it says the following:

"SEIU Local 1 has found no evidence that any extra staff have been hired to provide for the extra bath requirements. In fact what is occurring is greater use of"—and it's in quotations; their words, not mine—"'bath in a bag.' There is no basin or water used. There is simply a damp washcloth. In many nursing homes the flow sheets will indicate, this constitutes a bath. In other homes a quick morning wash and dress is now categorized as a sponge bath and again the flow sheets will indicate this constitutes a bath."

I was particularly concerned when I saw this in terms of the regulation change that was made and what might be one of the consequences of that in terms of what might actually be happening in long-term-care homes. Can you tell me, Minister, if Mr. Parsons brought this to your attention, since it was written to him, and has the ministry had any kind of investigation into the concerns that were raised by this local?

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Hon. Mr. Smitherman: As a result of the initiatives we've undertaken, there's a 1-800 hotline that people should call if they have concerns like that, and I would encourage people to do so. I believe that this phone line, and I'm working from memory here, has dealt with 9,000 or 16,000 calls. There's a new protocol in place that sees each of those triaged and investigated appropriately. So if people have an allegation or a concern like that, sending a piece of correspondence to a place that gets 200,000 pieces of correspondence is not the way to deal with a matter that's timely for residents. They should call those 1-800 action lines. I know them to be effective.

The second thing I would just say is—

Ms. Martel: Just before you go on, can I ask what happens if a staff person calls that hotline? Does their concern actually get responded to, or does it have to be a resident?

Hon. Mr. Smitherman: I'm not sure there's a requirement that people have to identify who they are, so I think that's irrelevant.

Ms. Martel: Can I get some clarification on that, please, Deputy?

Hon. Mr. Smitherman: Yes, we'll seek that out.

On the issue of whistle-blower protection, that's something we'll have a chance to visit as our long-term-care legislation comes forward.

Just another observation, for what it's worth—and I don't know whether anyone else has heard this as they visit long-term-care homes. I was at an event not so long ago with the Premier, where some long-term-care residents who are aged and fragile felt that the imposition of the minimum standard was an imposition on them, that as a result of a minimum standard that says two baths a week, they were being forced to have baths they didn't want to have. It doesn't negate the view that this is still an appropriate standard, but it does help to make the point that residents too have a voice around these things.

What we've sought to do is create more vibrant resident and family councils as part of the culture we seek to create, so that there is a voice within these various long-term-care homes that can ensure that where there are concerns around the way care is being delivered, those things can be addressed in an environment right inside the home. It stands as one more example of where imposing a regulation from government, which takes away the capacity of front-line health care providers and patients to be engaged in a conversation about their care, does have implications. Again, I'm proud of the regulation we introduced; I don't seek to change it at all. But I have heard directly from residents in long-term-care homes that some of them are being hustled off for baths they don't prefer to take. So I think

that there are different considerations that come into play as you get frail, and I think we need to have a system that recognizes these things too.

The Vice-Chair: Thank you very much, Minister. I think that concludes that part. Now we'll move to the government side. The Chair recognizes Mr. McNeely.

Mr. McNeely: Minister, I'm very pleased about the announcement of the family health team, together with Ottawa–Vanier. There are four communities in Ottawa–Vanier and one in Ottawa–Orléans where a family health team will be set up through the resource centres and service the francophone community. We're really looking forward to the announcement of the next applications.

We have a doctor shortage in Orléans, and I think that when you talk to people, it's throughout the province. The history of doctor shortages, of course, goes back to medical school enrolments in the 1990s. You were telling us this morning, on page 22 of your introductory remarks, that the people we're getting in the system now, we're not going to see until 2010 or 2011, so the doctor shortage is probably going to stay. The leveraging of doctors through family health teams seems to me to be an excellent method of looking after people. We went, on pre-budget, with the finance and economic affairs committee through some northern communities where whole communities were looked after by nurse practitioners, and that seemed to be working well. So we hope the family health teams continue.

Basically, what is the general status of the 69 that are already announced, and when will the new applications be coming out? We're very interested, and I'm sure a lot of communities across the province are interested in making new applications.

Hon. Mr. Smitherman: The first thing we have to acknowledge is that because the production line for a doctor—I often say it's not like producing a pizza; it takes longer than 30 minutes. Accordingly, communities across our province are paying a price for a decision taken in the NDP days that was slow to be responded to by the Conservatives. The NDP like to blame the federal government, and it's true that in the final days of Mr. Mulroney's government the idea was circulating that one of the things we needed to do to address increases in health care costs was to shrink our medical schools, and the NDP did that. For a period of five years in our province, we went with reduced medical schools. The Conservatives did increase those sizes again, but not until three years into their mandate. We're only now starting to see those doctors produced as doctors out on the front line of communities.

We should be careful not to lose sight that there is some good news to celebrate. We licensed more doctors in Ontario last year than in any year in the last 20. It's a reasonable sign of progress, but obviously it's not the whole thing. Family health teams are therefore an important part of our government's plan. You used the word "leverage," and I think it's a good word. As I said before, a doctor working in a group environment—not just grouped with other doctors, but in a multi-disciplinary environment—has the potential to service a greater number of patients than one who works in a stand-alone practice. A nurse is more than able to provide support to a new mom who takes her baby back to be weighed. A doctor should be there, of course, if the baby is experiencing challenges that require their attention.

Ontario communities and Ontario doctors: 1,400 doctors represented in 213 applications gave us a pretty good sign that the model we had developed of family health teams is a good one. We continue to be met with a great deal of enthusiasm. Progress is being made on each of the family health teams that has been announced. They are at different states and some of them were more formally evolved than others, which has allowed us to develop a series of quick wins. But the bottom line is that we're moving forward on these family health teams now. We're working very hard to give them the resources that they need to plan and to implement their plans, which means bringing on additional health service providers. We will be announcing a subsequent 30 family health teams in the coming months, and then we will have a third-wave application call, where we will open the application process back up because there are communities that have become interested in family health teams but did not get an application in on the first round. Then we will make that final wave of announcements subsequent to the close of that application process.

A basic message is that we're on target to introduce 150 family health teams to the province of Ontario. We think that this is a model of health care that is the future of health care delivery. It seems to be well reflected in the support that we garnered in our recent agreement with the Ontario Medical Association, especially from the young doctors of tomorrow. I think 97% of them voted in favour of our agreement, and central to our agreement was the principle of restoring the vitality of the comprehensive family practitioner.

Speaking a bit more particularly about the family health team in eastern Ottawa, the one that is in your riding: It takes a number of physicians and brings them together with nurse practitioners and other providers to dramatically enhance the number of people who can receive care. The quality of care that they're likely to receive will be very high indeed because it's a little bit like one-stop shopping; that is, you can see the appropriate provider in the same environment, and I think that's why this is likely to become a standard for the evolution of primary health care, not just here in Ontario but in other parts of our country.

Mr. McNeely: Just a further question, if I have time. The conditions for the doctors working within family health teams: We've heard of possible salary capitation. Are those job conditions, hours of work—that's what the doctors are asking us now—is that evolving as we get closer to getting these set up?

Hon. Mr. Smitherman: I think that a primary element of attraction for doctors—sometimes I talk to a stand-alone doc, someone who's working as a sole practitioner. Their quality of life seems a little bit like yours

and mine in the sense that there is an on-call nature to it. We meet with people who have a hard time being able to leave their communities to go on holidays because the burden of providing care has emerged in such a way that they don't have any teammates to work with. That's why group models of care have evolved, and the interdisciplinary approach is a very significant improvement on that. And why so? Because we need doctors who get to go home at night and spend time with their families. We can't continue to work on the principle that it's appropriate to ask a doctor to work 80, 90 or 100 hours a week, as some of them are currently doing.

The idea that you're working in a team environment where the circle of care is broader and—I don't like to use the word "burden" too much, but where the challenge of providing care to people is extended and where more hands on deck lightens the load for all. This seems to be a very important point that has made the family health team model one that a lot of doctors have said they want to be part of.

The Vice-Chair: Thank you very much, Minister. That ends the time. This committee will stand adjourned until 9 o'clock tomorrow morning.

The committee adjourned at 1600.

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