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Tuesday 8 April 2008

Mardi 8 avril 2008

Speaker
Honourable Steve Peters

Clerk
Deborah Deller

Président
L'honorable Steve Peters

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Hansard Reporting and Interpretation Services
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LEGISLATIVE ASSEMBLY OF ONTARIO

Tuesday 8 April 2008

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

Mardi 8 avril 2008

The House met at 1845.

ORDERS OF THE DAY

ONTARIO HEALTH PREMIUM
CONTRIBUTION-SANTÉ DE L'ONTARIO

Hon. David Caplan: I move that the standing committee on finance and economic affairs, as constituted by the assembly, review the Ontario health premium in accordance with section 29.2 of the Income Tax Act.

The Deputy Speaker (Mr. Bruce Crozier): The deputy government House leader has moved government notice of motion number 18. The deputy government House leader.

Hon. David Caplan: I'm going to be sharing my time with the member from Pickering–Scarborough East, the very able and capable parliamentary assistant to the Minister of Finance. My hope is that all members of the assembly will support this motion so that the matter can move on to the standing committee on finance and economic affairs and we can continue to implement the program of this government.

The Deputy Speaker (Mr. Bruce Crozier): I recognize the member for Pickering–Scarborough East.

Mr. Wayne Arthurs: Thank you, Speaker. I appreciate that. I'm pleased to speak to this motion tonight and anxious to see this motion brought before the standing committee on finance and economic affairs, under the capable leadership of the Chair, to have the debate around the Ontario health premium. As a member of that committee, I know the balance of the members of the committee are also anxious to have that opportunity.

I'm going to use my time this evening to speak a little bit about the plan we have—and had—and the record of success that we've achieved in managing the health care system in Ontario during the past five years, which was a direct outcome of our election. Certainly a very important part of that was the Ontario health premium, as part of the Income Tax Act, to make sure that we had the fiscal resources to be able to do exactly what the people of Ontario asked us to do, both in 2003 and 2007.

Our plan for achieving better health care is about keeping Ontarians healthy—not just about curing illness—providing high-quality care if they do become sick and sustaining the overall public health system for generations to come, not just for a year or two but for our children, our grandchildren and their children.

We're building on the success we've achieved in the past four years by investing in the universal public health care system. Investments in this system contribute quite significantly to Ontario's advantages as a place in which to invest, a good place to do business. It helps by lowering costs to business. If you have a healthy workforce, certainly the cost of business is lower. People are at work rather than staying home ill. It enhances the productivity of the province's workforce. Healthy people can go to work and do their jobs in a far more effective fashion than those who are laying in bed or in hospital, needing care at a stage when it's really late, when in fact we should be looking at far more preventive opportunities. And it helps in providing and supporting a high quality of life that is attractive to skilled workers.

People want to be in this province. They want to work in this province and in this country. You only need to travel and talk to our friends south of the border on occasion to hear how much they envy our health care system here in Ontario which provides the level of care that they so much would like to have at various points in their lives.

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We came to office in 2003. At that time, my predecessor was the then Minister of Finance, who presented her last budget at the Magna empire in Aurora. We know what that was all about. It was about a $5.6-billion deficit when we arrived. But the minister, government and members of the day were convinced in their own minds—or if they weren't convinced, then they really weren't being terribly straight with us—that they had a budget that was balanced. I'm not sure what led them to that belief. It certainly wasn't the numbers that led them to that belief. It was probably the tainted Kool-Aid.

We had a choice. We could have delayed the changes that Ontarians had voted for, or we had to ask Ontarians to make a further contribution to make up for the deficit that was left by the previous government, the deficit portion that we needed to manage the health care commitments that we had made. So a portion of that deficit—in effect, the health care portion—was covered through the new health premium as part of the Income Tax Act. We managed the balance through prudent fiscal management, savings we found in government and some support, obviously, from a healthy economy. We made the choice to invest in health care because Ontario families couldn't wait. They couldn't wait two, three, four or five more years, given the state of the health care system at that

point, for us to take the very actions they had asked us to take at that point in time.

I know, on this side of the House—the members here, including the Premier in his leadership role—that it was a tough choice to make. It was a tough choice because we had indicated a certain strategy we had in mind but we hadn't anticipated what we would find when we arrived here. But we made that choice. The government stood firmly behind that choice. In hindsight, it was certainly the right choice to make then and it's the right choice as we stand here today. It has meant, during the past five years now, that we've managed to have more doctors throughout Ontario, more nurses throughout Ontario and shorter wait times in particularly critical areas, in targeted types of areas. It has meant that we've put in for more free vaccines for our kids, that newborns have the opportunity to be assessed for disease that otherwise might have gone unnoticed. More newborns are getting additional screenings to catch diseases much earlier.

We were chatting just a few moments ago with one of our members here about the juvenile diabetes pumps and how well that's been received. Those things wouldn't have happened if we hadn't had such a strong commitment to health care. I don't think it would have happened if we hadn't had to make that very tough choice to invest more money in the system and stand so firmly behind the needs of Ontarians when it comes to their health.

It has meant shorter wait times for hip and knee replacements, CT scans, cardiac surgery, cataract surgery and other activities as well. As a matter of fact, I was in seeing my own doctor just in the past week or so. Some of the procedures that we take as standard for gentlemen my age and ladies my age, we're now finding those wait times—when I saw him a couple of years ago, his backup was about a year long before we'd get hospital time. Now, we were chatting, and he said, "I'm very pleased with the additional investments." It has meant more money in the hospitals, more money locally, and the wait times are down to four and five months for the procedures that are so important: screening to ensure that we remain healthy and, in the event that there's something going on within our bodies, that he's able to catch those things early.

The government is improving access. We're shortening wait times, we're promoting wellness through our health promotion ministry, we're preventing illness and we're modernizing the health care infrastructure.

We continue to invest heavily in e-health strategies, something that's direly needed. It takes a long time to get in place. With credit to the former government when it is due, they certainly undertook some of those initiatives. We've followed along that course of action. It will be some time before we have the e-health capacity that this province would so much like to see. But we're not going to get that unless we make the financial commitment to it and unless we're firmly behind health as a principal and priority area for spending and research in the province of Ontario.

The Premier is very fond of saying that for this province and this economy to truly succeed, we need everyone to be at their very best. "To be at their very best" means that they have to be healthy. That seems to be a pretty good start. How often do we say, "If you have your health, you've got everything"? It's important. When it comes down to it, "If you have your health, then you have everything." That's why these investments are so critically important.

The health premiums allowed our government to make unprecedented investments in our health care system, and I want to talk a little more about some of the positive ways that we made improvements to public health and how we've sought to resolve some issues that were left behind.

During the past five years, we have increased funding for hospital activities by $3.5 billion. That's no small amount. It's hardly chump change. We have increased funding for OHIP services by $2.8 billion—not just funding in the hospitals, not just those activities you need for direct care, but also the management of your health through the OHIP system. With those two things alone—without getting too far along—if I look at it, we have about $6.3 billion in increased spending for hospitals and OHIP services in and of themselves.

We have increased funding for Ontario drug programs by $1.2 billion. This is particularly important to our seniors. The Trillium health drug plan is an important part of them maintaining their health, and it's these kinds of investments that allow us to be able to provide that level of care.

There's been increased funding for long-term-care homes—over $1 billion in long-term care.

When you start looking at the quantum of the money that's been invested over the past five years, you begin to see the progress that has really being made. There are times in this Legislature where we've been talking about an element of—one piece of—long-term care or one piece of hospital care or one piece of OHIP care. But when we start looking at the quantum of the monies that have been invested and the outcomes that we're getting from those, you see the wisdom in having made the investments we did in ensuring that health care is a key priority for government.

Enhancing the quality of care for some 76,000 residents in long-term-care homes is so vitally important. That's not 2,000 or 3,000 people; that's 76,000 seniors who need that level of care.

We've increased funding by $800 million for community services by expanding home care and supportive housing. It's not just what happens in the doctor's office or what happens in the hospital or what happens in a long-term-care home; it's also what happens directly within the communities in which we live.

There has been increased funding of $600 million for public health promotion to ensure that people have the opportunity and are aware of the need to stay healthy, to do the kinds of things or the type of activity that keeps them healthy, so they're not, at the end of the day, draw-

ing upon the health care system unnecessarily. We want people to draw upon the health care system, the hospitals and doctors, when it's needed, and not because of neglect. To achieve that, we need to educate people. We need to build into the culture of what we do that health promotion is the first step in a healthy lifestyle.

There has been increased funding by some $1.2 billion to Cancer Care Ontario, emergency health services, mental health services and a variety of other programs. Each of us in this Legislature and our families, in all likelihood in one fashion or another, have been touched by cancer. As I mentioned to my colleagues just this morning, in the past week I've had a member of my family pass away from cancer. I know the treatment that he received, the support he had in the hospitals in his last few months when the prognosis was terminal—how important that was. So, on a very individual basis, I understand and can touch and feel the real need for the investments that we've made in our system.

The plan is working. It's working to help Ontarians stay healthy and provide better care when they need it. The McGuinty government is proposing, in the 2008 budget—we've been talking about that as well in the past few days—a total investment of some $40.4 billion in health care in the coming fiscal year. That's up from about $29.5 billion in the 2003-04 budget year. That's a $10-billion increase. That money is going into health. It's going into the doctors; it's going into nurses; it's going into hospitals; it's going into long-term-care homes; it's going into drug benefit plans; it's going into the physical infrastructure that's required—all of which the province desperately needs to have happen for the growing population, the aging population, the population we want to see stay healthy, and a population that we want to ensure that if they're not healthy, we can do everything we can to assist them back to a state of health.

The Ontario health premium has helped to ensure that our government has the ability to do exactly those things. It's certainly not the only piece. We mentioned some $40 billion in expenditures. The Ontario health premium is in no way a large portion of that, but it's a critically important portion, and I think it's critically important from the standpoint of the priorities that we set on health care.

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Every penny of the Ontario health premium is going toward improving Ontario's health care system, and this revenue helps to ensure that the government's ability to maintain health services is intact.

In this coming fiscal year, revenue from the premium itself is projected to be about $2.8 billion. That's up, I think, from about $2.4 billion, when it was first introduced, and that's a reflection of the growing economy we've had. This represents about 6.9% of total expenses for the ministries of health and long-term care and health promotion.

So, you see, it's only a very small portion of the overall part, but a critically important part if it were not there and available.

There's certainly discussion along the way about eliminating that health tax, taking it out of the system, removing $2.8 billion or more from the system. That would be a dramatic cut to the system. We can't go back to the days where we had nurses in large quantities across the province losing jobs. We can't go back to the days when we didn't have doctors available to us. We can't go back to the days of closing hospitals.

We're making very significant investments in our infrastructure, our hospital infrastructure in particular, and we're going to need the revenue stream that goes with that, on a go-forward basis, to ensure that we can operate the existing, the renewed and the new facilities.

We can't be closing hospitals and emergency rooms, and we can't be losing hospital beds by the thousands. That's the experience we had before 2003. We can't be allowing medical school spaces to just flatline and not get addressed.

We lost the potential for hundreds of doctors over about a five-year period, from the late 1990s into the early part of this century. We didn't increase the opportunity for foreign-trained doctors, and we missed opportunities that would have existed there as well. We lost thousands of nurses.

We've been down a particular road, and the elimination of the health premium, the lack of focus on health care as a budgetary priority, would do nothing but take us back to where we were.

We've made very strategic investments and achieved very tangible results in the past five years. The government and those who are providing health care, the service providers, have worked very hard to ensure that health care has improved for all Ontarians.

In fact, more than 500,000 Ontarians who didn't have a family doctor a few short years ago now have one.

During the last five years, from 2003 to 2008, more than 8,000 new nurses have been hired. They're providing services to each of us and our families and those in our communities in hospital settings, in home settings and elsewhere.

We're proposing in the budget to increase the family health team numbers by adding 50 new health teams, starting this year, to the 150 that are already in place. These are particularly important because we're going to be focused on rural and underserviced communities. We all know the issues that exist in those communities when it comes to attracting and keeping physicians, when it comes to having the type of care that's necessary, when it comes to the proximity to that care. It makes the capacity to have the health teams so very important to those communities—it tends to augment what otherwise might be more limited, a direct opportunity to have ready access.

For those in northern Ontario, the budget, this year, is proposing to add about $13 million to the northern health travel grant. Those from northern Ontario are probably more aware than I may be of the needs of their constituents to be able to get to health care. If people can't afford to get there, they need a means to get there. Adding

some $13 million to the northern health travel grant will help to ensure that people in northern Ontario, more remote areas, are achieving the same level of access, the same opportunity for access, that might exist for those who live in more urban or southern environments.

We've more than doubled the number of training and assessment positions for internationally trained medical graduates. Some 200 physicians per year have been added since 2004. We're taking advantage of the expertise that's out there. We're taking advantage of those who have been trained elsewhere. We're taking advantage of those who have come to this country and want to practise the skills they have, to help augment what's here and also to give them an opportunity to take advantage of their chosen professions.

We're also proposing in the budget to move toward the hiring of 9,000 nurses by 2011-12, in that budget year. That's going to take some additional investments of $500 million over three years.

We're proposing a further $90 million in this budget year to support full-time employment opportunities for Ontario nursing graduates. I think one of our great successes was the commitment to full-time employment to nursing grads who choose to stay here in the province. If we're taking the opportunity to train those young people—more often young people—it certainly is an advantage if they choose to stay here in Ontario to practise their skills. If we can offer them full-time opportunities to get started, it's likely they're going to settle down in their own communities, settle down here in Ontario and practise their skills throughout their career.

The government is improving access to health care for seniors as well. The proposal to hire some 2,000 nurses for long-term-care homes and provide $107 million over about three years to move toward the hiring of 2,500 more personal support workers in long-term-care homes will go a long way to add additional support to those in our community, mostly seniors, who need to have and take advantage of the long-term-care-home opportunities.

We are also calling in the budget for $278 million over three years to address various programs that are needed in these long-term-care homes. We know the issues around physiotherapy that is needed, the personal support that is needed for seniors in those facilities. These monies will help to augment that in a significant way.

We're looking additionally at $700 million over three years to invest in the aging-at-home strategy. So many of our aging population would prefer to stay in their own homes, either with the support of a spouse, a partner or a caregiver. But to do that they need to have the capacity from the community at large, the professions at large, to come and add additional support. It should be, and is, something we want to achieve, allowing seniors, those who need that care, the dignity of being able to stay in their homes and have the quality of care that's possible before they would have to transition to some other type of care.

We've increased first-year medical school enrolment by 23% between the time we took office and this year. That's a fairly significant increase in the percentage of new grads coming out of medical school.

We're going to expand the nurse-practitioner-led clinics by providing some $38 million over three years. I think that was a question this afternoon. The Premier spoke briefly to it, about the importance of nurse practitioners and nurse-practitioner-led clinics.

More health services are available now in the community than ever before. This includes the government's funding for residential hospices as a part of an end-of-life care strategy. As each of us have an opportunity over a period of time to watch loved ones as their lives end, an opportunity to do that in a comfortable, home-like, supportive fashion is something we would probably all want to see. Hospitals are not the best place in which to have one's life end. Although the care is great, if one can find a means by which the residential hospice program can provide a more conducive, family-oriented, comfortable style of life in those last days and weeks, it's certainly better for those folks and something we should be continuing to invest in.

We've increased the number of community health centres to 76 from 54, and the number of satellite CHCs to 27 from 10, serving an additional 200,000 Ontarians. I know one of those satellites is planned in my community. Actually, the first of the community health centres that was there was an offshoot of a youth program that was started in one of our community facilities. They found they had to move down the road. There wasn't a facility available. Because of the growth in the community, this satellite is now a very comprehensive community health centre, focusing primarily on young people, which is really interesting. They have a number of programs. They encourage young people into their programs to get health care. So I'm very anxious to see the completion of the satellite CHC.

In this budget, just this year alone, we're proposing to increase to 200 from 150 over the next four years the number of student spaces for primary health care nurse practitioners and to expand the number of undergraduate spaces for midwives, up to 90 from 60 over the course of a year.

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Not only are we looking at how we can get more nurse practitioners in the system but at what other professionals we can augment by providing additional spaces that will help with health care. Midwives are a great way to do that. A lot of young women, primarily, who would have their children in a hospital are now considering midwives and midwifery as an option, but to be able to support that we need to have the midwives in place. With their support, it keeps those young ladies out of the hospital at a time when they're giving birth. It's certainly a cost savings to the system. Those resources can be used elsewhere, but it is also a far more natural form of childbirth for them.

The results show that since 2005 the government has achieved real success in reducing wait times in very key procedures. I want to give you just a couple of very

specific examples with respect to the wait time reduction, as we put together a wait time strategy and, with the Minister of Health, put together a means by which these could be monitored, could be promoted, could be shown to be accessible for folks.

Cataract surgeries: The wait time is now down 191 days, or reduced by 61% from where it was.

Angiography: The wait time is down some 26 days, almost half the time that one would have waited earlier for angiographic assessment.

Knee replacements: The wait time is down 196 days, almost 50%. Those in this Legislature and elsewhere who have family members who have had knee or hip replacements know the pain they go through during the time they wait for those replacements. In the case of knee replacements now, by cutting the wait time by almost half, they can move on with their rehabilitation and get back to a very normal life.

CT scans: The wait time is down from 32 days, or almost 40%.

When we start talking about the percentages, we've cut the time by more than half: for cataract surgeries, down 60%; angiography, 47%; knee replacements, 45%; CT scans, 40%; hip replacements, 37%; angioplasty, 32%. Although not down to the same degree as some of these other assessed matters, even cancer surgeries are now down some 15% in their wait times.

To further reduce wait times, the budget is calling for some $17 million over a three-year period to fund the operation of an additional five MRI machines, resulting in some 21,900—almost 22,000—additional scans. Without that type of assessment, it's hard to move forward in identifying exactly what the problem is and getting folks on to necessary procedures that allow the activities to occur.

The budget proposes further to decrease wait times by investing $180 million over three years to create incentives to shorten emergency department wait times and improve patient satisfaction. I can tell you that in our own community, with the redevelopment that is going on at the local hospital, the Ajax-Pickering campus of the Rouge Valley Health System, a significant amount of that investment is going into the emergency department. It's probably now handling about two to two and a half times what it was designed for. As projected, it will probably be handling about three times the number that it was initially designed for by the time the redevelopment is completed and the new emergency department is open.

We desperately need, not only in my community but throughout this province, to be able to invest in the quality of emergency care that gets people in and gets them the service they need, to the extent that they have to go into another process, whether it's being hospitalized or something more modest—or get them in and get them out again, to determine that the emergency care is much more limited. But having folks wait for extended periods of time even to be assessed just adds to the stress level that goes on, and often we end up with assessments that probably are more conservative simply because there's an anxiety that exists about providing a type of assessment that will allow someone to go home more readily.

To assist those hospitals in very high-population-growth areas—and certainly the 905 Golden Horseshoe would be among those; not the only ones, but just the concentration of population—we're proposing to invest some $120 million over three years specifically to assist those hospitals in high-population-growth areas to help meet anticipated demand that's going to come.

To make some further improvements, the number of general surgeries proposed in the budget is proposed to increase by about 12,500 cases during this year, rising to some 30,000 surgeries by 2010-11. That's a lot of additional surgeries that folks are anxiously and necessarily waiting for.

We want to continue to focus on active and healthy lifestyles, health promotion and illness prevention. Ideally, if we can prevent illness through health promotion strategies, fitness strategies and healthy living, we will save ourselves and the system a lot of unnecessary costs and apply those resources against those in our community who really need them. We're proposing to invest some $47 million in 2008-09, growing to some $239 million in just three short years, in e-health systems such as the diagnostic imaging systems, the drug and lab information systems and the diabetes registry, as just examples of things we're trying to achieve.

We have some recent examples, which include the implementation of the smoke-free Ontario strategy. We took our lead from a number of municipalities in which smoke-free actions were well received by communities-at-large. The province picked up on what others had done in that regard and made it a more composite strategy throughout Ontario. It's being well received throughout the province.

In addition, we've added vaccines, as I mentioned really early on. Three vaccines were added free of charge to the roster of recommended childhood vaccinations. Those savings could be anywhere up to about $600 per child, per family. That's a big savings to a family with a newborn child.

We're proposing to increase prevention and the early identification of chronic diseases. We want to start with diabetes. There's some $100 million in new funding to work on that increased prevention and early identification strategy.

I know that we have the resolution, the motion that's before us, to have the Ontario health premium as part of the Income Tax Act moved to the standing committee on finance. I, for one, as I'm sure with other members do, look forward to the opportunity to have it before us.

I have a lot more that I could add to the activities that the government is undertaking in respect to our health system over the past five years. To a large extent, that's as a result of the health premium; not in the composite total dollars, but certainly that's a big part of it. More important, in my view, is the capacity for us to focus our attention very effectively, in a very concentrated fashion, on health of Ontarians. The health premium, of which

every dollar goes to health care, is helping us to be able to provide the very core and important investments we're making to improve the health of Ontarians. I look forward. I hope this motion sees its way through so it can go to committee and we can have the debate there, at the standing committee on finance and economic affairs, before the matter is brought back before this Legislature for further consideration.

The Deputy Speaker (Mr. Bruce Crozier): Further debate?

Mr. Tim Hudak: Mr. Speaker, I'm just confirming the rules on a motion. I—

The Deputy Speaker (Mr. Bruce Crozier): Just to explain, with the help of the table, if you refer to standing order 25, you'll be able to understand that there are no questions and comments on this motion.

Mr. Tim Hudak: Thank you for the clarification.

I'm pleased to respond to the motion on behalf of the PC caucus, as the finance critic.

Interjection.

Mr. Tim Hudak: No, my friend, you have another hour. You sat through the first one, you poor fellow, and now you've got to sit through a second one.

I listened closely to my colleague for Pickering–Scarborough East, who is the finance parliamentary assistant for the government. I assume he'll be hanging out with us again at the finance committee when this motion is enacted. I look forward to that committee, I suppose, just to see what is really going to happen at that committee. I'll describe why I'm curious momentarily, whether this is actually a review of the so-called health tax or if it's just an exercise in redundancy and the members have already been given their marching orders and will simply approve the tax, give it a blessing and continue on. I hope it's not the latter. I hope that there will be a genuine review, with witnesses called forward to talk about it, to offer suggestions. But that remains to be seen.

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I do take a bit of exception to my colleague from Pickering–Scarborough East's comments. To hear him tell the tale, this is one heck of a health tax. He spoke about an increase in funding of $3.5 billion to hospitals, $2.8-billion increase in the OHIP budget, a $1.2-billion increase in the Ontario drug benefit plan, $600 million into health promotion, $1.2 billion to Cancer Care Ontario, mental health and some other programs, for a $10-billion increase in health spending. To hear the member describe that, boy, this is one miraculous little health tax. It brings in approximately $2.6 billion, perhaps up to $2.8 billion, this year. So how this tax manages to bounce around from the hospital budget to the OHIP budget to long-term care to health promotion and multiply itself by a factor of four and five is nothing short of miraculous; how a $2.6-billion income tax increase can finance a $10-billion increase in annual spending—we may as well call it the breads-and-loaves tax. It's almost like the Lord's miracle itself is happening when it comes to tax revenue, to see that multiplied several times over, which I think belies the Liberal argument that this funding goes into any particular program.

I know my colleague, an intelligent individual and experienced lawmaker as well, knows that this money simply flows into the consolidated revenue fund, the giant treasury hanging out there at the Minister of Finance's office. Every dollar that a working family or a senior pays in the so-called health tax goes into that big pot of revenue over at the treasury office. You could have said that the health tax goes to pay for all the highways in the province of Ontario. It also pays for police. It also pays for funding for municipalities. It also pays for cultural products and tourism. This miraculous little health tax multiplies itself like the bread and loaves.

Mr. Robert Bailey: The industry minister's trip to China, maybe?

Mr. Tim Hudak: Maybe, as my colleague says, it's paying for the Minister of Economic Development and Trade's junket to China later in the week as well.

I know that seniors who are living in Mount Hope or a middle-class family in Fenwick would not happy to contemplate that the $600 to $900 that they may be giving up as a family would be financing a trip for the Minister of Economic Development and Trade to Shanghai, I guess it is. Or is it Beijing? We're not sure exactly, because the whole junket has been very secretive. We're not sure when or where. Maybe I'll get into that a little bit later on. I want to makee some introductory comments about the bread-and-loaves tax.

I will take issue with my colleague. I know he will say certain things as the parliamentary assistant, but I think we all know full well that it's nothing more than an income tax increase that flows into the consolidated revenue fund; and who really knows exactly where it goes at the end of the day?

Just for the heck of it, I had my hard-working staff, Trisha Rinneard and Joel Hoidas dust off good old Bill 106. Bill 106 will live in the halls of infamy when it comes to broken promises, because Bill 106 was the one entitled An Act to implement Budget measures—Honourable Greg Sorbara, first reading June 21, 2004; a day that will live in tax infamy because it brought in the so-called health tax.

In case we have forgotten, Dalton McGuinty made a promise to taxpayers, in order win votes in the 2003 election, that he wouldn't raise taxes.

Mr. Robert Bailey: He signed his name to it.

Mr. Tim Hudak: He signed his name to it, signed a document with the Canadian Taxpayers Federation. He spent hundreds of thousands, millions of dollars on television ads where he looked through the screen and looked people in the eye and said, "I will not raise your taxes." Maybe I needed a bigger screen. I didn't see his fingers crossed down below the screen. Maybe I didn't watch the end of the commercial where he sort of winked at the camera and said "I don't really mean this." I suspect the game was afoot for Dalton McGuinty to say, "You know what? I will make this promise to win votes in the next election, and then we'll bring in a tax increase

once we're safely secured with the keys to the Premier's office and such." That is why Bill 106 by the Honourable Greg Sorbara, June 21, 2004, will live in the tax hike hall of fame and in the broken promises hall of fame.

I did hear a good joke once, that this was Dalton McGuinty's GST, because it stood for the Greg Sorbara tax. Have you heard that one before? No? I heard that one came from the Liberal caucus, actually. Maybe not. So this is the Liberal GST, the Greg Sorbara tax, the infamous broken promise tax. Here we go.

You'd think that maybe the Ministry of Health Act would have been opened up when this so-called health tax was brought in—that the money would go to the Ministry of Health and therefore it would be the Ministry of Health Act or something like that. But, interestingly, it's the Income Tax Act that is amended in Bill 106 in the hall of fame of broken promises.

It says, "The Income Tax Act is amended to impose a tax called the Ontario health premium." Oh, it's just in name only. It's actually an income tax increase, it says right here in the bill. "The new section 2.2 imposes the tax and the new section 3.1 governs how it is calculated. Consequential amendments are made to other sections of the act." That's the explanatory note, as you will recognize, Mr. Speaker.

So you turn to section 1(1) of the Income Tax Act definition: "Ontario health premium," in quotes—it's ironic. It's in quotes; it really is in quotes. "'Ontario health premium' means the tax described in section 2.2."

So it's not a premium, or the latest parlance that the environment minister uses, "fee"; it's nothing but a tax hike on the backs of families and seniors in the province of Ontario.

Section 2:

"The Act is amended by adding the following section:

"Ontario health premium

2.2 (1) Every individual shall pay a tax, called the Ontario health premium, for a taxation year ending after December 31, 2003 if the individual is resident in Ontario on the last day of the taxation year."

Section 4 goes into considerable detail on how to calculate the new income tax that Dalton McGuinty brought in. I'll get into those levels momentarily, but there's considerable detail devoted to how to calculate this new income tax, I remind you again, called a health premium in name only—the bill itself says it is a tax on income.

This is interesting. There's actually a section in here about how to calculate the health tax upon somebody's death. You'd think if it were actually a health premium, some sort of user fee for health care, you wouldn't pay it once you're dead; it just wouldn't make sense. You might want a rebate, for example, depending on your circumstances. But like an income tax, you'd have to pay it on the income earned during that year, whether you used the health care system or not. I found it rather ironic that even in death the tax is charged under certain circumstances.

The other interesting thing we came across, Mr. Speaker, and maybe you've encountered this in your constituency office, is that of provinces that actually have a health premium, a real, genuine health premium, which is a user fee for the health care system—you get rebated. You get rebated if you leave the province, for example, because you're not using their provincial health care system. Therefore, you can get rebated. I can't remember the province in particular, but I'll say British Columbia by way of example; I may be wrong, but it's a western province. If you move to Ontario, you could actually have that rebated.

We had constituents where the shoe was on the other foot, where they were charged a new income tax that Dalton McGuinty gussied up as a so-called health premium, moved to another province and then were trying to get a rebate from the Ministry of Finance. Because the Ministry of Revenue really wasn't created then to welcome Minister Chan into the assembly; it was all at the Ministry of Finance at the time. They were trying to get a rebate and they thought that since this is the way it works in other provinces where there is a health care user fee, they would be rebated because they'd moved out of the province. But no such luck. I know you're in suspense, thinking they must have received their health premium back because they moved from the province and they no longer used the health care system, but they found out to their chagrin that it was nothing more than an income tax and therefore fully payable despite their residency in another province.

So no refunds. It's a health premium in name only. In reality, as illustrated by Bill 106, it's an income tax hike on the backs of middle-class families, lower-income individuals and seniors in the province of Ontario that flows directly to the consolidated revenue fund.

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Let me talk a bit about this exercise, though, because we're debating the motion before us tonight. My intention is to support the motion. I would like to see this actually reviewed as outlined in legislation and at the very least, perhaps for entertainment purposes, see how the government members on the committee are going to act, if there will be a genuine review process or we simply sit down and vote before we get our first coffee and move on with a lopsided vote calling for the Dalton McGuinty's income tax increases to continue.

Here's the other point I forgot: Bill 106 also has in it this review mechanism that we're debating tonight:

"Review of Ontario health premium

"29.2 (1) A standing or select committee of the assembly shall be appointed to review the Ontario health premium within four years after this section comes into force.

"Same

"(2) The committee shall begin its review on or after the date specified by the assembly, which date shall be no earlier than June 30, 2008, and shall report the results of its review to the assembly no later than December 31, 2008."

I suspect that section was added so that Liberal members could go into the next election campaign and

say, "Wow, it's going to be reviewed. We had to do it, we had no choice"—that's the cover language they use—"but it will be reviewed. Don't worry about it We can do something about it down the road."

So section 29.2 exists in the legislation. But then, boy, old habits die hard. Every penny raised in Dalton McGuinty's income tax increase, and then some, has been spent on runaway spending. Witness recently the 110% growth rate in the $100,000 club, for example. So Dalton McGuinty decided, "You know what? I need that money." He basically did.

Even the former finance minister, Minister Sorbara, had indicated in the run-up to the 2007 election that the health premium was part of his budget for 2007-08 but it would be reviewed subsequently, in 2008. Remember that? A bit of leg was shown there and he said, "We'll flirt a little bit with taxpayers and we'll review the health tax in 2008." Then Dalton McGuinty contradicted Greg Sorbara, then finance minister, in the run-up to the election campaign, and used an expression like, "I need the money."

March 19, 2008, in scrums, a member of the media asked the Premier, "Have you decided not to review the health tax?" He responded, "We're mandated by law to review the health tax, and we will do that." The follow-up question, an obvious question: "Are you going to overrule that in the budget?"—meaning, overrule the sensibility of a review, I guess. The Premier responded, "I made it very clear before the campaign and during the campaign what my view is on that." "So what's the point of going through the review?" the media ask. The Premier replies, "Because we're legally obligated to do so. I think the outcome is pretty predictable."

So again, I look forward, at least out of curiosity, to see—the Premier has already made his mind up that he's not interested in changing his income tax increases, but we're mandated to go through the review—what kind of committee process will actually unfold.

I know some of the members in the committee, and I know that they want to do some hard work on this and actually review the income tax increases and come up with some suggestions, I'm sure: to change, to rescind—something like that. But the Premier has made up his mind. He says he needs every penny to fuel his funding for things like, I suppose, the Ontario cricket club that received $1 million when they asked for $150,000; we all remember that.

On September 6, 2007, Dalton McGuinty said, "I'm saying if you're looking to me to eliminate your health premium in 2009, don't look to me for that.... We need every single penny of that premium." He says he needs that money.

Do you ever read the St. Catharines Standard? The Minister of Transportation would definitely read that, and my colleagues from Welland riding—the old Niagara Centre—and Niagara Falls for sure. I would encourage members to read it. At the very least, if you're going to be opening up the website for the St. Catharines Standard, go back 11 or so days ago.

The headline: "Health Tax Review is a Pointless Exercise"

The editorial says:

"If a promise is made to do something, but there is no intention to act beyond keeping that initial promise, is it really a promise worth making?

"Or keeping, for that matter?

"That is what Ontarians should be asking Premier Dalton McGuinty when it comes to his controversial health care premium....

"At the time," when the tax was brought in, "many hoped this would mean the beginning of the end of the tax," meaning the review, "that, after five years the government's books would be balanced and the tax would be redundant." In fact, this year the government had $5 billion in additional revenue beyond even what it projected, meaning that it was really awash in cash, thanks to the sacrifices of middle-class families and seniors in the province of Ontario. But instead of making any attempt to reduce that tax burden or to follow up on these expectations that the health tax would actually be reviewed in a serious manner, Dalton McGuinty and his finance minister decided to pretty well spend every penny of those funds and shovel them out the door.

Let me read that line again; I think I digressed a bit: "At the time, many hoped this would mean the beginning of the end of the tax, that after five years the government's books would be balanced and the tax would be redundant.

"The good news is McGuinty is going to follow the legislation and press forward with the review. The bad news is he isn't going to do anything to the tax that costs every working Ontarian up to $900 dollars each year."

They have that quote from the Premier: "'I think the outcome is pretty predictable,' the Premier said last week."

The editorial responds: "Ah yes, there's nothing like a predetermined conclusion to inspire voter confidence in the study.

"If there is no desire in the McGuinty government to scrap, or at least reduce, the controversial health premium, then why is the government wasting resources reviewing it?

"Despite the tax bolstering provincial coffers for more than four years now, the problems plaguing health care then plague health care today.

"Emergency rooms are still crowded.

"Long-term-care homes are still short beds, which has a trickle-down effect on the availability of acute-care beds in our hospitals.

"The only way to get many non-emergency surgeries or diagnostic imaging done in a timely manner is to go across the border and pay for it yourself.

"Family doctors and nurses are in critically short supply."

That's a St. Catharines Standard editorial. Apparently, Mr. McNeely may have read it—I'd encourage him to do so. In their conclusion: "There's a funny relationship be-

tween governments and revenue; it's not unlike that between smokers and nicotine.

"It's an addiction.

"Never mind that in the mad dash before the end of the fiscal year McGuinty spent nearly double the $2.6 billion raised by the health tax each year; if the tax were cut, McGuinty would have less to dole out to his pet projects," wrote the St. Catharines Standard. "Or as the more cynical may call it, less to buy votes with."

Good for the Standard. They pinned the tail on the proverbial donkey there. They called it as they saw it, that for this so-called health tax—a bit of an income tax increase—a line was put in Bill 106 at the time to try to have an out so they could say to taxpayers, "Don't worry; in the next election it will be reviewed—hint, hint, nudge, nudge, vote for me. It'll be gone." Then we see, several months after the election, in March of this year, Dalton McGuinty says, "I changed my mind and I need that money."

You know, as I said a bit earlier, old tricks die hard. A leopard can't change its spots. The same kind of thing is happening with this tire tax, by the way; the same sort of thing.

Interjection.

Mr. Tim Hudak: Yes, I know. They're not calling it the tire tax premium; I guess they're calling it the tire tax fee, to try to disguise it as another tax grab. It is ironic. History is repeating itself. It was Yogi Berra, right? "Déjà vu all over again." Is that his line? It's the same sort of thing. Premier McGuinty, before the election, says, "I have no intentions of raising this tax." Safely elected to office, he has the Premier's limousine, he has the staff, the $100,000 club, all that kind of stuff: "You know what? To heck with what I said before the campaign. I'm going to bring in this tire fee tax once in office."

Let me go back a little bit. You might remember—the Liberal line has changed a little bit. They're saying now that the health tax is necessary because it funds $10 billion in health care expenses. Even though it's a $2.6-billion income tax increase, this somehow funds $10 billion in health expenses. The original cover story here—remember this, Mr. Speaker?—was that they needed it to fix a structural deficit. Remember that? I'll have a few comments here to debunk this notion of the structural deficit to begin with.

But what is revenue up? Is it $26 billion, $28 billion, something like that, in the last little while? The health premium is $2.6 billion, $2.8 billion of that. Sorry; see, I got caught in that propaganda. Dalton McGuinty's income tax increases—$2.6 billion, $2.8 billion of that. So this notion of it being to finance the structural deficit is a bunch of—is "hooey" parliamentary, Mr. Speaker?—horse feathers, as my colleague from Niagara Centre likes to say. It's simply fuelling runaway spending.

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But back in the day, Dalton McGuinty said it was needed to fix a structural deficit. Then what did they do? I was talking to my friend from Northumberland the other day here in the assembly. He said, "Well, the Auditor General did a study, and the Auditor General said there's a $5.6-billion deficit, and that's why we needed this income tax increase gussied up as a health tax."

It wasn't the Auditor General, right? We've heard people say this in the assembly. It's not the actual reality. It wasn't the Auditor General. Erik Peters was no longer the Auditor General. He was hired in the capacity of a consultant, paid for this particular work and given a bunch of assumptions to try to force a certain conclusion—great for the cover story. I think that's the reality. That's my recollection, because Erik Peters was not the Auditor General at the time, and he was given a bunch of suggestions.

What were the assumptions Erik Peters was told to have in his report? "I think that the economy will basically stay in recessionary circumstances," something to that effect, or very, very slow growth. Basically, Erik Peters was told by the finance minister to assume that the effects of SARS and the effects of the hydro blackout would be throughout the entire year, and assume that kind of growth rate for revenue. Assume also, therefore, that agencies like the LCBO, the Lottery and Gaming Corp., and other sources of non-tax revenue, would similarly experience recession-like circumstances. They also told him to assume that the government could find absolutely no savings whatsoever. Even though this government says it finds a billion dollars of savings—I don't think they've actually demonstrated that, but they say they find a billion dollars in savings each year—Peters was told, in his capacity as a paid consultant by the government, to assume no savings could be found, that there would be absolutely no asset sales whatsoever.

Mind you, the election was in October 2003. We were pretty much in election mode through summertime. The writ was formally dropped in late August or early September, something like that. The budget was April? Late March? So basically, the then-PC government was in office for less than half a fiscal year, and then the McGuinty Liberals took over for the other part of the year. I think everybody knows that any kind of deficit figure is for a year, not for a short number of months.

Here is the important point, though: Despite that, despite the myth surrounding Erik Peters's report and the trumped-up circumstances the government had as his underlying assumptions, despite that, when he came out with his numbers on October 29, 2003, Dalton McGuinty said there was a $5.6-billion problem. Then what do you think he said? I don't know if my friend from Ottawa–Orléans remembers. He might say, "Well, he said he's going to bring in this health tax." That's actually not in keeping with what happened and therefore not part of reality. Interestingly, after this report came out—this smoke-and-mirrors report, October 29, 2003—do you know what Dalton McGuinty actually said? It would impact his government's ability to implement some of their platform, but he would still not raise taxes.

So let's get this straight: Dalton McGuinty's mythology around his income tax increases has been, "We

needed it to fix a structural deficit." The mythology that some of the members opposite talk about is that the auditor came up with this number; it's not true at all.

Mr. Robert Bailey: They drank the Kool-Aid.

Mr. Tim Hudak: I think a lot of Kool-Aid has been passed out over there for the past four years, because the reality is not in keeping with what actually happened on the historic record.

Anyway, Dalton McGuinty's one-time mythology was, "We needed the tax to pay for a structural deficit." But he actually got that report back in October 2003—a couple of days before Halloween, ironically—Dalton McGuinty said he's not going raise taxes. Here we go: McGuinty news release, October 30, 2003: "The McGuinty government ... will ... maintain personal income tax rates." How about that? This looks like the promise that kept breaking itself.

That's kind of what he said during the campaign. He has this report in hand that he has doctored up to suggest that there's a $5.6-billion structural deficit. Despite that, he says, "We're going to maintain personal income tax rates." And I showed you how he actually, months later, increased income taxes in Bill 106.

Well, maybe he made a mistake. Dalton McGuinty is prone to say one thing and do another; I think my colleague from Northumberland would acknowledge that. He says one thing and does the opposite.

On November 1, 2003—my birthday, by the way; that's why I remember this.

Interjection.

Mr. Tim Hudak: Yes, I am a Scorpio. Can you tell?

On November 1, 2003, Dalton McGuinty goes on Focus Ontario—a great show, on a very important network, Global; Sean Mallen does a very good job—and says, "We will not be raising taxes." There you go. Maybe he's going to actually keep this campaign promise.

Then they have the throne speech. Some people say maybe that's when they announced the so-called health tax, income tax increases. But no. The throne speech contained this statement:

"So this new government made a commitment to maintain personal income tax rates at the current level.

"Legislation will be introduced to keep that commitment."

Holy jumping—my grandmother, who used to live in Sarnia, now passed away, loved that expression.

Interjection.

Mr. Tim Hudak: You know, my grandpa's actually a big NDP supporter.

Interjection.

Mr. Tim Hudak: I don't know if they would've voted for Bob Bailey, but Bob Bailey, on his own personal characteristics, may have convinced him—who knows?

On November 20, 2003, Speaker, lest you forget, Dalton McGuinty said:

"So this new government made a commitment to maintain personal income tax rates at the current level.

"Legislation will be introduced to keep that commitment."

He was on a roll. He followed it up the next day in the Sudbury Star: "We're not going to raise taxes. That's just not on the table." This is after the election, right? This is after he has his Erik Peters report—months later. November 21, Sudbury Star: "We're not going to raise taxes. That's just not on the table."

There is another one, Speaker, in Hansard. You know Hansard is always right. November 24, 2003: "We are going to maintain personal income tax rates...." And in question period, December 17, 2003—that was the day, by the way, the government released their economic statement of the province's finances—Dalton McGuinty said, "I just don't believe that Ontario families should have to pay the price.... I'm not prepared to encumber them with further taxes." Holy jumping, here he is, just over a week before Christmas, saying he's not going to increase taxes.

So he's had this Peters report for several months after the election and Dalton McGuinty is still saying he's not going raise taxes. By then, because we're standing here, we would've seen if his fingers were crossed. You would've actually seen that, or caught the wink, wink, nudge, nudge.

This is the crazy one. Are you ready for this one? April 24, 2004, now four months down the road. Back on Focus Ontario, CanWest Global station, April 24, 2004, Dalton McGuinty said, "Well, what we said all along—I am very clear about this—is that we're not going to be raising taxes." April 24, 2004. So you have this trumped-up Peters report—September 22, 2003—right? Am I right about that? No, sorry, October 29, 2003, and then six months later, at the end of April: "I'm very clear about this. We're not going be raising taxes." What happened three weeks later? Three weeks later, on May 18, 2004, Dalton McGuinty brought in his first budget and announced a whopping tax increase on income of up to $900 per person, and if you had two income earners in the household, it could be up to double that rate—three weeks later, May 18, 2004.

Now let me point this out: Just a couple of weeks ago, when federal Finance Minister Flaherty visited Ontario on a number of occasions and was pressing the provincial government to reduce income tax rates—

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Hon. Madeleine Meilleur: If I was you, I wouldn't talk about it.

Mr. Tim Hudak: I say to my friend the minister, this is why it's important to talk about it.

He said he wanted to see Ontario's economy flourish and called for lower taxes in the province of Ontario, which now, sadly, under Dalton McGuinty, leads North America in the highest taxes on business investment. So Minister Flaherty called for these things.

What did Finance Minister Dwight Duncan—and, if I am wrong, I suspect Premier McGuinty—say? "The budget's already been written." Basically, the budget decisions had been made up weeks ago, so there was nothing they could do. They said Flaherty was just playing games, because the budget was already written.

Remember this? The budget was already written, things were under way, decisions were made. But Dalton McGuinty, only three weeks before the budget was brought in, said they weren't going to raise taxes; three weeks later, taxes were raised.

So we either have to believe that something happened in that three-week period, where he suddenly changed his mind after a campaign, saying six to eight times that he wasn't going to raise taxes; or was the budget decision already made all along? Was is already under way? This was a brand new tax increase in the province. There's a complexity to it in terms of the income levels. It's something you wouldn't do overnight, I suspect. So did Dalton McGuinty actually go on Focus Ontario and say that he wasn't going to raise income taxes when he knew full well that in the budget preparation there was an income tax increase? Did Dalton McGuinty actually go on Focus Ontario and say something that he knew was not in keeping with the facts?

We'll talk a bit more about the Peters report. I know my colleagues on the government side like to talk about it a lot, even though they inaccurately characterize it as a report by the Auditor General. I'll leave that on the floor, too. I do hope that in further debate from the government members they'll explain to me why Dalton McGuinty, three weeks before the budget, was saying that he wasn't going to increase taxes, when I suspect the budget process to increase income taxes was already well under way.

Using the Peters report, the McGuinty government argued that a structural deficit was not a one-year anomaly in an otherwise healthy fiscal situation. They argued that it was a structural deficit caused by several years of much faster growth in program spending than in government tax revenues. This was created after the fact, because Dalton McGuinty, right up until three weeks before the budget, was still saying he wasn't going to increase taxes. But this after-the-fact cover story was that Dalton McGuinty would use that as political cover to introduce a significant, permanent income tax increase, the so-called health tax.

If you actually look at the Peters report, if you blow off the dust on it, if you can still find a copy—I suspect a lot of the original copies are buried with the 2003 Liberal platform underneath those new homes on the Oak Ridges moraine—you'll note that Peters clearly concluded that there would be a $5.6-billion deficit for the fiscal year, based strictly on the assumptions given to him—given to him—by the Ministry of Finance. Peters, in his capacity as a paid consultant, did not say there was a structural deficit. He focused only on a potential deficit in the fiscal year 2003-04, strictly under the assumptions that he was given by the government.

The Peters report was mainly about revenue shortfalls in that one very unusual year. He said that revenue in 2003-04 would be $4.4 billion less than budgeted, and that represented a substantial majority of the potential deficit of $5.6 billion, based on the assumptions that he was given. What were those assumptions, again, and how did they impact Peters's numbers? Peters estimated $961 million in lower crown corporation revenues because of SARS and the blackout. That's typically the OLGC, the LCBO, and maybe with some other crown agencies. So he estimated $961 million due to SARS and the blackout. He estimated $1.16 billion in lower tax revenues due to SARS and the sudden appreciation of the dollar. That's coming from the other general tax revenues. He cited an increase in $722 million in SARS-related health spending and $130 million in tourism tax breaks after SARS.

We know, thank God, that SARS didn't last throughout the year.

We also had the blackout that started in Ohio.

The Minister of Finance, the former Minister of Energy—he's actually quite notorious for this—when you listen to his language, he seems to imply that the province of Ontario caused the North American blackout, at least on the eastern seaboard. He uses language to convey that, unfortunately, and I hope that he changes that because he knows that's far from the reality.

Anyway, we had the blackout for some period of time. It was in August 2003.

Peters's assumptions basically were that the slowdown with SARS and the blackout and such would continue throughout the year.

Peters also assumed that $771 million in increased transfers from the federal government would not flow. In those days, when there was a Chrétien government, you were never really sure if they would keep their promises on transfers to Ontario.

Mr. Lou Rinaldi: What is the Harper government doing?

Mr. Tim Hudak: Boy, oh, boy. My friend from Northumberland really helps me a lot here.

The biggest increase in the province's fiscal picture has been personal income taxes, which are up $5.8 billion from 2004 until the plan for 2008-09. The second-biggest increase is $4.3 billion in transfers from the federal government. This has taken place primarily in the time of the Harper government. I know my friend from Northumberland wants to make sure that due recognition is given to the increase in transfers from the Harper government. I'll give you the numbers.

The Canada health transfer is $8.8 billion in the plan for 2008-09, and in 2004-05, when your friend Paul Martin was in there briefly, it was $5.6 billion. The Canada social transfer was $2.9 billion then, and now it's $4 billion. So there has been a significant increase in transfers from the federal government.

I'm merely pointing out that your friends Mr. Martin and Mr. Chrétien were not overly generous to the provincial coffers. Maybe your new friend Bob Rae, if he has the opportunity—I don't know if that will necessarily happen. I know that members like the member for Northumberland are very big fans of Stéphane Dion. I find that rather curious. I find him a little bit weak as a leader. I'm not sure exactly what he stands for, and he's having a lot of trouble keeping his party together. But you have your reasons for supporting Stéphane Dion.

I think I've answered the member for Northumberland's questions—that health transfers have actually increased substantially over the last number of years.

Back in that day, you were never really sure if Jean Chrétien would come through with federal transfers for health care, so Peters had assumed that $771 million wouldn't flow. That was part of his matrix in figuring out what you call the structural deficit. In reality, miracle of miracles, a few months later the transfers did actually happen, as outlined in the Eves budget for that year.

Peters also accepted Liberal assumptions that there wouldn't be the estimated $381 million in year-end savings, even though Liberals have since included estimated year-end savings in subsequent budgets, increasing steadily to an estimated $1.1 billion of the 2008-09 budget.

So cumulatively, the one-time issues Peters identified amounted to almost $3 billion, and together with the CHST, it actually materialized in $300 million in year-end savings; $4.04 billion of Peters's forecast is accounted for within a couple of months.

That kind of thing didn't stop Dalton McGuinty, I'll tell you. Even though he promised right up until the budget was being finalized and sent off to the printers that he wasn't going to increase taxes, he went ahead and did just that with his income tax increases disguised as a so-called health tax.

Mr. Robert Bailey: The giant sucking sound.

Mr. Tim Hudak: The giant sucking sound of jobs to other provinces, or money from people's pockets?

Mr. Robert Bailey: That, and the money out of your wallet.

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Mr. Tim Hudak: Let's look at some of the figures here. It's important, I think, to look at the current budget and previous budgets to put Dalton McGuinty's income tax increase into perspective.

Projected government revenues in the 2008 budget hit an all-time high at $96.9 billion, an increase of $28 billion, or 41%, from 2003. It took from Confederation, John Sandfield Macdonald here in Ontario, to Ernie Eves to get to $68 billion for government spending, and Dalton McGuinty has it up to $96 billion in five years.

Dalton McGuinty shredded the Taxpayer Protection Act in order to impose a tax. Oh yeah, remember that? He ignored the option to put the question to the electorate in a province-wide referendum. Remember that? Dalton McGuinty signed that document, put his hand in the air and said that if he were going to break that promise, he'd at least put it to a referendum and put it to the people of the province of Ontario to accept the income tax.

You could have brought that case to them. You could have said, "You know what? We're going increase your taxes by $900 each, but we promise you it will go into health care," or what have you. So why not put that to a referendum like Dalton McGuinty said that he would. But one Dalton McGuinty promise is worth as much as the last one, which doesn't get you very far these days. So Dalton McGuinty also ignored that and refused to put the question in a province-wide referendum like he once promised that he would.

Here is the other zinger. Remember this one? It's almost like we're looking at the old top 10—

Mr. Robert Bailey: K-tel.

Mr. Tim Hudak: The top 10 hits of the health care record. Here is another one: The McGuinty Liberal government stretched the truth to suggest that all the money raised by the health tax is actually spent directly on health care. This was the original gambit. They said, "Okay, we're going to call this income tax increase the health tax and we're going to promise we're going to review it in four or five years so we can win votes in the 2007 election. And do you know what? Let's figure out some way to try to tell people that it's going into health care."

So grab your 2004-05 budget. Do you have it with you?

Interjection: Yes.

Mr. Tim Hudak: Well, look through it. Do you remember they listed all of the programs that were funded by the so-called health tax? They actually had a list. This is the brain trust at the time. You know what? If it were genuinely a health premium going into health care services, that would be a reasonable conclusion to make: Here is your health premium; it's going directly into health care; here are the four or five—

Interjection.

Mr. Tim Hudak: Oh, Lou, you weren't listening to me for the first half hour of my speech. Don't make me repeat it.

Mr. Lou Rinaldi: But look at all the hospitals we're funding.

Mr. Tim Hudak: You missed my bread-and-loaves line. Your colleague—

The Deputy Speaker (Mr. Bruce Crozier): Members, I feel a little left out up here. Direct your comments through the Chair, please.

Mr. Tim Hudak: Mr. Speaker, remember that my colleague from Northumberland's colleague from Pickering–Scarborough East said that the Ontario health tax goes into hospitals, into OHIP and the Ontario drug plan, health promotion, Cancer Care Ontario, mental health etc. If you total that up, it's $10 billion of spending. You tell me how a $2.6-billion income tax increase finances $10 billion in annual spending. It is the bread-and-loaves tax. It is amazing how it ricochets to any program of the day that you want to propagandize.

The reality is that it goes into general revenue. Initially—remember this? In 2004-05, it was a legitimate idea at the time. If it truly was a health premium and going into health care, then you list the programs it's going into. So the government in their 2004-05 budget listed the programs that received funding from the health tax. Do you remember that? Come on. It was a good one. You listed them. I should have had the whole list with me. It became a controversy here in the Legislature because underneath the programs funded by the income tax increase gussied up as a health premium, you had listed

sewer projects—remember that?—sewer projects, as well as Ministry of Tourism and Recreation advertisements to encourage exercise.

Mr. Bill Mauro: You've grown a beard since you've started.

Mr. Tim Hudak: Well, there's just so much history here; it's worth recounting. It spurred a lot of debate within the Legislature. Do you know what their initial reaction was? To describe sewer funding as health care. That was your initial spin. The tourism advertising was also health care, because I guess they were getting up and moving around a little bit to see all the beautiful sights in the province, and you described these as health care. You got to the point, I say to my friend from Northumberland, where you were going to describe pothole-filling as health care because it made it easier for ambulances to drive across. That's about the stretch that was happening in the debate at the time.

That was a major, major embarrassment. I know my friend the public infrastructure renewal minister would have gone back there and he would have to said to his friend Jim Warren, who was described today as the chief government fixer, "There's no way that we're going to do this again." Caplan went in there and he said, "No way we're going to do this again." So that whole exercise has disappeared. It is no longer listed in the budget where the health tax revenue goes after the whole sewergate of 2004-05. Now they say they've come up with a new idea, to say it goes into everything under the sun.

Here's the reality. Dalton McGuinty's so-called health tax is punitive, it is regressive, and it hits middle-class families the hardest. It is unaffordable for working families and seniors who have trouble making ends meet in Dalton McGuinty's Ontario.

Interjection.

Mr. Tim Hudak: It's true, I say to my friend. I would think that as a member of the Ontario Liberal Party, you would prefer progressive means of taxation and you don't like regressive taxes. I'd ask my colleague if he supports, for example, a flat tax. The usual criticism of a flat tax is that it's regressive because higher-income people don't pay as high a proportion of tax as they would under a progressive income tax system. That's the usual argument you would expect to receive.

So, imagine the irony to find out that this income tax increase disguised as a health premium is actually more regressive than the flat tax. Let me explain. A person with a taxable income of $25,000 has to pay 1.2% of her income for the health tax. A person earning $72,000 per year pays just over 1% of her income for the health tax. A person earning $200,000 per year pays 0.45%. And a millionaire—your friend Frank Stronach, who you just gave the $25-million grant to—

Interjection.

Mr. Tim Hudak: You've got your own Magna budget now, with that $25-million grant that Frank Stronach—oh, picture this.

Interjection.

Mr. Tim Hudak: No. I didn't rank a front-row seat in those days. I had to work hard to get here.

Picture this. This was a time when Magna was considering buying Chrysler. Do you remember this? Magna was considering buying Chrysler, and in your Magna budget, you guys forked over some $25 million to Magna. We're not even sure what that money has really gone to yet.

So Frank Stronach, for example, would pay only 0.09% of his income into the health tax.

So less than one tenth of a per cent is the rate for the highest incomes, and 1.2% of income for the lowest-income individuals, subject to the Income Tax Act dressed up as a health premium—a highly regressive tax.

I know my colleagues on the government side who are on the finance committee are going to fight this tooth and nail. If they're not going to get rid of the health tax, at the very least they will address the regressive nature of the health tax. Please tell me it's so.

Here's another oldie but a goody in the health tax hall of fame. People in Ontario pay the so-called health tax twice.

Interjection.

Mr. Tim Hudak: My colleagues say, "What are you talking about?" Let me give you a bit of background. When Dalton McGuinty broke his solemn promise not to raise taxes by introducing the so-called health tax, which is nothing but an income tax increase, he placed an unacceptable burden on lower- and middle-income taxpayers and cost Ontario jobs. If that was not bad enough, the people of Ontario will now be paying for it twice—paying for it twice—through higher transit fees, hydro bills and property—

Mr. Jean-Marc Lalonde: Yes, yes. You left us—

2010

Mr. Tim Hudak: I swear you don't listen to my speeches, I say to my friend from Glengarry–Prescott–Russell. I just explained that whole thing. That was your cover story for a short period of time, and you've given up on that one. You have other cover stories now.

But listen to this. When Greg Sorbara, the finance minister, came to your caucus and said, "We're going to bring in our own GST, this health tax increase, this income tax increase," I bet you didn't expect that you would pay it twice. The reality now, four years later, is the cities of Toronto, Ottawa and London are three of 11 public and private sector employers that have lost grievances filed by their unions that will force them to pay for their employees' health premiums. Arbitrators across the province have fielded 55 similar grievances on a case-by-case basis since this tax came into effect in July 2004.

So 11 public and private sector employers, including those in Toronto, Ottawa, London and now Hamilton as well—I represent part of that area now, the upper Stoney Creek and Glanbrook area—have to pay the health tax, which is kind of surprising. The reality was, because Dalton McGuinty did not want to admit that he broke his promise not to raise taxes and raised income taxes, that

he used this title "premium," which got him into all kinds of legal trouble, a big quagmire because of the old OHIP premiums from the 1980s. At issue were clauses dating back to Ontario's old OHIP premiums that forced employers to pay the levy. First introduced in 1972, the OHIP premium was eventually eliminated in 1989. However, many unions insisted on retaining the clause that employers would pay for these premiums in their contracts. It worked for them, right? They made that decision and kept it in the contracts. I don't know if they knew Dalton McGuinty would come along, but here comes Dalton McGuinty, he calls his income tax increase a premium for political purposes to try to sugar-coat it, and these old clauses kicked in. Dalton McGuinty wanted Ontarians to believe that the so-called health tax was not actually a tax increase, so he labelled it the Ontario health premium—a little sugar-coating on the tough medicine.

In his first budget, on May 18, 2004, Dalton McGuinty talked about a premium. The budget document stated in no uncertain terms, "Legislation will be introduced to create the Ontario health premium with every cent dedicated to health and only health." Oh, yeah, that's right, like sewer projects and tourism advertising.

McGuinty was so nervous about the backlash this new tax would generate that he took out radio ads telling Ontarians, "I'm Dalton McGuinty, and I want you to know that every penny of Ontario's new health premium will go to health care." That is, if they kept the radio on loud enough and long enough after hearing Dalton McGuinty's voice, that's the sentence they would have heard. However, as soon as the collective agreement issue popped up, McGuinty began singing a different tune, "Our intention has always been crystal clear"—it's ironic. Does he say this with a straight face? Come on. "Our intention has always been crystal clear, that the Ontario health premium is a tax and not the OHIP premium that had previously been imposed under the Health Insurance Act." First of all, in his radio ad, he's saying it's a health premium and then, when the collective bargaining agreement popped up, McGuinty said, "Well, no, it's actually just a tax."

The Ontario PC Party first asked about this in 2004 and Dalton McGuinty said there was nothing to worry about—the kind of language he uses on the economy, right? "Don't worry; be happy. Nothing to worry about." In October of that year, he said, "If there is some uncertainty connected with this matter and we have to act, then we will do so, to make it perfectly clear that this is something that is to be paid by taxpayers." So he said it was a premium to try to sugar-coat it and sell it to the electorate, even though he wasn't courageous enough to put it before a province-wide referendum like he promised he would. Then he gets caught up in all these collective bargaining agreements because he had called it a premium when in fact it was an income tax increase, so he starts backpedalling and says, "Well, it's really a tax, not a premium." Then he says, in answer to a question in the Legislature—asked by Mr. Runciman, if I recall—that he would act to make it clearer that it is a tax and not a premium.

But now, four years later, Dalton McGuinty has still yet to act to bring in that clarification legislation. Maybe that's what this review is about. Maybe that will be part of the review process, that he will clarify exactly what he means.

For example, taxpayers in the city of Ottawa—the OC Transpo contract meant that taxpayers in Ottawa are on the hook for an extra $1.5 million a year and $4.5 million retroactively. If you're working in a restaurant in Ottawa, if you're working in a car dealership in Ottawa, you pay your Ontario health tax—courtesy of Dalton McGuinty, that income tax increase—and on top of that, now you have to pay what was then $6 million in back pay because Dalton McGuinty tried to gussy this up as some kind of premium.

In the city of Toronto, the decision for the TTC will cost the public agency approximately $18 million in back pay and $6 million per year into the future. So if you're working in the city of Toronto, working in a retail outlet by way of example, you're paying the health tax out of your own pocket, plus you're paying for the collective bargaining agreements because Dalton McGuinty tried to say this was a health premium, rather than being gutsy enough to say that it was actually a tax increase.

Ontario Power Generation, London Hydro, Norfolk Power Distribution, all lost their appeals and are picking up the tabs. The costs pass on to users in those systems.

LaPointe-Fisher nursing home, the city of Hamilton for the firefighters' association, National Steel Car, among others, were impacted by the way this health tax was sold.

In my last comments in the last minute I have available, unless there is unanimous consent for me to continue—

Interjections.

Mr. Tim Hudak: The tire tax fee—déjà vu, here we go all over again. Before the last election, Dalton McGuinty said that he would not bring in this tire tax, and he said, "Do you hear me? Are we all clear?"

The election happened, and then we had another conversion on the road to tax Damascus. Dalton McGuinty said, "I'm going to charge a tax anyway," and a provincial budget that they've boasted was going to be tax-hike-free was followed three days later by the announcement of the brand spanking new tire tax fee: $4 to $6.

Then, a couple of days later, other electronics are going to be taxed as well, so I'm sad to say that while they were boasting about a tax-free budget, it still contained this old income tax increase and brand new taxes several days later.

The Deputy Speaker (Mr. Bruce Crozier): Before we proceed, I have been advised that in the Kraft Hockeyville competition, the winner has been determined.

I'm further advised that two names come up on the screen of communities: Roberval, Quebec and Kingsville, Ontario. But I am sad to advise that Roberval,

Quebec, was the winner. I want to thank everyone who supported Kingsville in this competition.

Further debate?

Ms. Cheri DiNovo: I am so sorry about the results. Please, take our condolences from the New Democratic Party of Ontario.

I was most pleased, as always, to hear my eloquent friend from Niagara West–Glanbrook and his hour-long dissertation on the tax that isn't; as he said so eloquently, the GST—the Greg Sorbara Tax. It really did raise for me that wonderful day when Greg Sorbara was the finance minister and stood up in this House to announce the so-called new child tax benefit—a tax benefit that would amount to $250 for the poorest children in Ontario—while wearing shoes that were worth $256 and while clawing back about $1,200 from the federal national child supplement. So a fond memory.

Another fond memory that he brought to mind as well, was, of course, the infamous one now of the Premier of Ontario signing his name and saying, "There will be no new taxes." I appreciate that. It's always good to walk down memory lane and to remember promises broken. Of course, there were many of them. I think we lost count at about 26.

2020

There's no question that the Liberal Party of Ontario is a party of Bay Street and not Main Street. If there's anything that shows that, it's this health tax. Again, as we've heard, this is not a progressive tax; this is one of the most regressive taxes. A couple of examples: First of all, a bank teller making $26,000 a year pays $1.2% of his taxable income in health tax, while a lawyer making $150,000 a year pays only 0.5% of her income. Another one is that an auto worker making $45,000 pays 1% of her income in health tax, while a CEO—many of them friends of our friends opposite—making $500,000 pays only 0.2% of his income. I will go on with other examples of how regressive this regressive tax is.

I also point out again, somewhat redundantly after my friend from Niagara West–Glanbrook, that I hope the required committee process to look at this bill is going to be a genuine one. I hope that deputants from across the province come and say exactly what their experience with the so-called health tax is, how regressive it is, and have a chance to speak about—and this is the central point—whether this health tax has made Ontarians healthier.

Of course, our contention in the New Democratic Party is that it has not, that Ontarians are not healthier under the McGuinty Liberals than they were before this health tax was imposed, or before there were McGuinty Liberals in power. I want to point out a few aspects of the health of Ontarians under this new imposed health tax.

First of all, we heard from Campaign 2000 that one in eight children live in poverty. We all know that you cannot live in poverty and be healthy—not as healthy as you could be. For example, this government says they're going to bring in $1 extra per week for poor children in their budget. That is not going to keep that one in eight children healthy.

I point out that this is also a government that is closing the pools across the city of Toronto. I've lost track of the number of e-mails I get from parents who are concerned about obesity rates, about the health of their children. Yet somehow, this government continues along to close those pools when keeping them open would cost a mere $12 million or so; again, something that they could really do that would help poor children.

But back to the health tax and more stinging examples. An accounting clerk making $30,000 a year pays a shocking 24% more in income tax, while an insurance executive making $200,000 pays only 3% more. A restaurant manager making $50,000 a year is paying 16% more in provincial income tax, while a bank executive making $200,000 pays only 3% more. Finally, an average working couple with two $50,000 earners pays $1,200 more in provincial income tax, so it's certainly a regressive tax; there's nothing progressive about this. One would expect the higher-income earners, with a progressive tax, would pay more, not less—in fact, they pay more under this tax, again, a tax that was never supposed to be, because the Premier of this province, Dalton McGuinty, promised that he would not raise taxes.

Let's look at the dental health of Ontarians. Are they healthier with this health tax under the McGuinty Liberals? Certainly not. My husband and I had the wonderful opportunity to go to Sweden just after Christmas. It's really interesting that you can see in Sweden—it's not alone—and other Scandinavian and European countries vibrant economies. They're not losing jobs by the hundreds of thousands over there. We know them for having Sony Ericsson, Volvo, and H&M—for having many other companies, of course. And they're nine million strong. There are only nine million people in Sweden, far less than we have in Ontario. We have about 13 million people. For some reason, they can afford to have cradle-to-grave social services. For some reason, they can afford to have free dental up to the age of 18. But no, not here; not in Ontario, not with this regressive health tax.

Here we see children get, according to this last budget, $90 only for the poorest children, $90 extra a year. Anyone who has been to a dentist recently—I know many who are watching have taken their children to the dentist, those who can still afford to—you'll know what $90 a year buys. It buys an extraction, and it's going to have to buy an extraction, because there's certainly not enough money in this dental plan, as put forward by the McGuinty Liberals, to pay for dental health—not real dental health. That's preventive dental health. That's going in for cleanings and checkups. That's not here. So dental health is not particularly healthy, particularly for the poorest in McGuinty's Ontario, under this health tax.

Of course, as New Democrats—the party of Tommy Douglas, after all; the party of medicare; the party that stands for universal, accessible health care for everyone; the New Democrats who always stood for this—we knew

that this would be an ongoing fight. Tommy used to say that you could never rest with universal health care. It always has to be extended and it always has to be guarded.

We don't see it guarded here. We see an increase of public privately built hospitals. We see an increase—and this is shocking, actually, quite shocking—an increase of hospitals that are going to be running deficits; over 60% of them. We know they're not supposed to, but yet, on the front page of the Toronto Star today, we see that they are letting go of nurses. This was supposed to be the government that was supposed to be hiring nurses. What could possibly be going wrong here? Obviously, this government is not fully funding health care, despite the imposition of this extremely regressive health tax.

We in the New Democratic Party have always called for fully funded health care, nothing less. This tax does not provide this. This tax just provides an added burden on the poorest among us.

Another aspect of health care, a major aspect of health care, is the health care of families. I find it phenomenally ironic that as we sit in this chamber, there is a function going on downstairs for Equal Voice. Equal Voice wants to see more women in this Legislature. Certainly, the honourable member from Nepean–Carleton has called for family friendly legislative hours. We heard vague murmurings from across the aisle of no more night sittings. Why do we always and consistently vote against night sittings? Because they're not family friendly. Because for women who have to look after small children, this is not conducive to a political career. Because women who have to look after small children need to be able to go home at night or they will not see their children.

So of course, this is an anti-woman move, an anti-family-health move and an anti-family friendly move. Ironically, here we sit enabling this, while Equal Voice downstairs calls for more women in politics. We're not going to see more women in politics if we continue with the kind of hours that the McGuinty Liberals call us to put in here.

What about seniors? Has the health tax made Ontario's seniors healthier? One might just walk into any long-term-care facility and ask a senior there or their family and you'll get a pretty straightforward answer from most of them. I know I do in my constituency, and I've heard from them across the province.

Before this life, as members know, I was a United Church minister—and by the way, a friendly amendment to my friend from Niagara West–Glanbrook: It's "loaves and fishes," not "bread and loaves."

Mr. Tim Hudak: Oh, is that what I said?

2030

Ms. Cheri DiNovo: It's okay. It's good. A friendly amendment to your speech: loaves and fishes.

So if you walk into long-term care, what do you find? You find overworked, harried staff. You find administrators trying to penny-pinch at every turn. You find them still struggling under this meagre per-client hour of care problem that, again, the McGuinty Liberals promised to address and have not. In fact, this new budget brings in—what?—five or six minutes extra of care a day—obviously not enough, obviously not adequate, obviously not what our seniors need and deserve. These are the ones who, after all, have paved the way for all of us here.

Are our seniors healthier with the McGuinty health tax? No, our seniors are not healthier with the McGuinty health tax.

My colleague from Nickel Belt will talk about community health centres. She knows about them better than anyone else in this Legislature, and she'll talk about the fact that almost every year they come with hat in hand, asking, begging, for more money from this government, and never receive enough.

Let's go back to why the health tax is more regressive than one would like. In fact, it's even more regressive than the pre-1989 premium. Under the previous premium regime, almost 70% of premiums were paid for by employers. Not any more. We know that this lent an air of fairness to an otherwise, what we would have considered, still regressive flat premium. By implementing the health tax as a surtax on personal income tax, the government has made it next to impossible for an employer to pay the premium, even if they wanted to do the right thing and help out the lower-income earners who are working for them. Even if they wanted to, it's almost impossible to do that.

In the 2007 campaign, the NDP proposed a change to the health tax that would put money back in the pockets of 75% of working families by providing a health tax rebate of up to $450 per person and $900 per two-income family. So you see, this government does in fact have a choice. It could exclude low- and moderate-income Ontarians from paying this tax at all, if they wanted to. They're a majority government. They can do what they want. Why don't they want to help out middle- and lower-income Ontarians? Why do they insist on being a party of Bay Street and not a party of Main Street?

We also proposed to phase in the elimination of this health tax for 1.5 million workers earning under $48,000, and that would put $450 back into the pockets of individuals earning between $48,000 and $80,000—middle-income earners, hard-working people who are trying to get by, who thought that they had been promised that their taxes would not be raised and, in fact, found that their taxes have been raised. We think that's unfair. We think they deserve a rebate.

The NDP plan is a balanced approach that I think might accomplish some of the aims of this government—at least, purported aims—that only puts money in the pockets of lower- and moderate-income Ontarians who need it the most—that's what we're purporting—while protecting health services by ensuring that banks, insurance companies and the well-off pay their fair share. Of course, when we really look at the friends of this government—again, the friends on Bay Street—we see heading the list those selfsame banks and insurance companies and the well-off.

Just to conclude—I'm going to be sharing my time, as I've said, with my colleague from Nickel Belt, our emi-

nent and able health critic—for those who are listening at home, when you think about this health tax, a health tax that goes against the promise of the Premier of Ontario, who promised he would not raise taxes more than once; he signed his name to it, in fact—it is a health tax that is completely and utterly regressive, that hits the poorest and the middle-income earners the most and hits those who could most afford it the least. Surely this government, who pretend that they want to do something about poverty, will at least do the right thing and really look at this health tax, really get deputants, really commit to reviewing this health tax—which we suspect, we fear, is not actually the case.

Again, has the health tax made Ontarians healthier? The answer from Ontarians across this province, the answer from the New Democratic Party, is a resounding, absolute no.

The Deputy Speaker (Mr. Bruce Crozier): We'll have to ask for consent because you yielded the floor and didn't tell us that you were sharing your time.

Ms. Cheri DiNovo: I did.

The Deputy Speaker (Mr. Bruce Crozier): You did? I'm sorry. There were a couple of ears up here that didn't hear that. Let's continue. The member for Nickel Belt.

M^me^ France Gélinas: We're here to talk about the Ontario health premium, but let's call it by its real name: the health tax of the McGuinty government. That was, in 2003, a promise that we all know was not kept. That was the first of a long series of broken promises. There were to be no tax increases in Ontario. They campaigned on a promise of no new taxes in Ontario, yet we got this Ontario health premium.

Not only is it a new tax; to add insult to injury, the tax is grossly unfair. I'll give you some examples. If you make $30,000 a year of taxable income, your income tax has gone up by 24%. If you make $50,000 a year, then your income tax has gone up by 16%. But if you're one of the wealthy ones and have made $200,000, then this tax only represents a 3% increase in your income tax. This is the reverse pyramid that doesn't make any sense. We are actually punishing low-income earners by taxing them more. The system is supposed to work the other way. It's supposed to be that as you make more money, you are in a position to pay more taxes. But with the McGuinty government, they have it all in reverse: The less money you make, the more we will punish you with that health tax that was not supposed to be there at all.

What are we talking about in real terms? We're talking about a lot of money. We're talking about a couple who makes $50,000 a year who will pay $1,200 more in income tax. This a huge amount for anybody.

They would have us believe that because we have this health tax, our health care system is doing so much better. They would have us believe that it has reduced the number of people who haven't got access to a family physician. Well, in 2003, before the tax was introduced, over 100,000 people in Ontario did not have access to primary care, did not have access to a family physician. Fast forward to right now, to 2008: There are 100,000 Ontarians who don't have access to primary care, who don't have a family physician.

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Quand la taxe nous a été présentée, tout le monde pensait que, bon, on aurait plus d'argent, on verrait un impact positif sur notre système de santé. La première chose que les gens regardaient, c'est, « Est-ce que je vais finalement avoir accès à un médecin de famille? » En 2003, quand la nouvelle taxe était mise en place, il y avait plus de 100 000 personnes en Ontario qui n'avaient pas d'accès aux soins primaires. C'est-à-dire, ils n'avaient ni accès à une infirmière praticienne, ni accès à un médecin de famille. On est rendu en avril 2008, et on a encore 100 000 personnes en Ontario qui n'ont pas d'accès aux soins primaires, qui n'ont pas de médecin de famille et qui n'ont pas d'accès à une infirmière praticienne non plus.

Pour ces gens-là, s'ils tombent malades, ça veut dire des longues lignes d'attente à l'urgence, ça veut dire des cliniques sans rendez-vous, mais surtout, ça veut dire qu'il n'y a aucun investissement de fait pour garder les gens en santé. On parle de promotion de la santé, de prévention de la maladie. Bien. L'accès aux soins primaires, c'est le premier pas, c'est un pas important pour garder les gens en santé.

They would have us believe that because we pay this regressive health tax, we now have access to more nurses, who are, as we all agree, at the heart of the health care system. They are telling us that they will invest in 9,000 new nurses within the next mandate. We have some bad news here. Anybody who read the headlines—hospitals have to balance their books, and they're doing it by letting nurses go, to the tune of—today, 72 full-time nursing positions will be taken out of Rouge Valley. That means that the nurses everybody cherishes, the nurses who are at the core of our health care system, are losing their jobs. We're not talking about adding here; we're talking about losing nurses.

Quand on parle de la taxe, on nous dit que ça va aider le system de santé. On nous dit qu'on va s'en servir pour financer plus de postes d'infirmière dans le système de santé de l'Ontario. Ils ont même chiffré ça à 9 000 nouveaux postes d'infirmière dans le prochain mandat. Moi, je leur dirais que ça commence pas mal mal. Pour tout le monde qui sont capables de lire les journaux, on a vu que l'hôpital de Rouge Valley a annoncé que 72 postes à temps plein d'infirmière devront être coupés afin qu'ils puissent balancer leur budget. On ne parle plus d'en ajouter; on parle de couper des postes. Les infirmières, c'est la seule profession qui est là 24/7, au chevet du client tout le temps. C'est une profession que les gens respectent. On a besoin de plus d'infirmières en Ontario, mais la situation est telle dans notre système de santé qu'on ne voit pas le nombre augmenter. Les postes sont en train d'être coupés.

On nous parle également des équipes santé familiale. Les équipes santé familiale, c'est le modèle du gouvernement McGuinty pour régler les problèmes d'accès dans les soins primaires. On a annoncé avec grande fanfare et

tout ça au moins 150 nouvelles équipes. Mais quand tu regardes un petit peu plus loin, tu te rends compte que ce n'est pas 150 nouvelles équipes parce que la plupart de ces équipes-là, c'étaient des groupes et des réseaux de soins primaires qui existaient déjà. On leur a donné un nouveau nom, une nouvelle formule de financement à la McGuinty, puis on nous a dit, « Voilà, on vient de créer 150 nouvelles équipes. » La réalité est très loin de ça.

They would have us believe that because we pay this health tax, Ontarians now have better access to primary care; they now have access to 150 new family health teams that work under an interdisciplinary team, and that will be the legacy of this government to improved access to primary care. Well, let's look at what the 150 family health teams are all about. Most of them are a rebranding of existing primary health care teams. They used to call them family health networks. Some of you were probably signed up in family health networks, and now nothing has changed but you're in a family health team. You were maybe served by a family health group. Well, nothing has changed, but you're now in a family health team. Those 150 new family health teams? Allow me to be a little bit disappointed here, because we're not talking new; we're talking repackaging of existing primary health care services that were there before and are now being called new. A few are new. There's one in my riding, City of Lakes family health team, that is actually under construction. It's a new one, but most of them were existing teams that got rebranded.

I want to talk about community health centres a bit. The community health centres have been in existence since the 1970s. They have been studied to death and proven to be the most effective way to provide primary care to a given community, yet after all these years, after 36 years of being looked at and analyzed, Ontario still hasn't got a province-wide network of community health centres.

Community health centres are community-governed, linked to their names. That means they have a board directors, volunteers, who we often say are the eyes, ears and conscience of the community. They are the link to the community, and they sit on the board and give the governance of the community health centre. The community health centre has a small team of people who do administrative work, and then they have their team of primary care providers. Every community health centre has physicians. Most of them have nurse practitioners, nurses, dietitians, social workers etc. That's their primary care team.

They also have health promotion teams, which look at things like the healthy baby clinics, smoking cessation and increased exercise. What makes the community health centre different is that they also have a community development team, and this is where work really takes place, work based on the determinants of health to make the people of Ontario healthier.

So, rather than expand the network of community health centres, the McGuinty government decided to rebrand it to family health teams. None of them have community development workers, none of them have health promotion workers, and most of those family health teams are a rebranding of existing networks.

J'aimerais parler un petit peu du besoin d'expansion des centres de santé communautaire en Ontario. Les centres de santé communautaire, de par leur nom, sont dirigés par un conseil d'administration. On dit souvent de ces bénévoles qui siègent au conseil d'administration qu'ils sont les yeux, les oreilles et la conscience de notre communauté. Ils sont le lien au conseil d'administration du centre de santé pour donner la gouvernance, les directions stratégiques etc. De ça, il y a une petite équipe de gestion, mais il y a également trois grands programmes dans tous les centres de santé.

Le premier, c'est le programme des soins primaires. Dans le programme des soins primaires on retrouve médecins, infirmières praticiennes, infirmières, nutritionnistes, diététistes, travailleuses sociales etc., basés sur les besoins de la clientèle qui est desservie par le centre. Ceci est l'équipe des soins primaires.

On y retrouve également une équipe de promotion de la santé. Ce sont des gens qui vont étudier les besoins de santé de la population et qui vont mettre en place des programmes de promotion de la santé et de prévention de la maladie. On y retrouve des sessions pour aider les gens à cesser de fumer, les aider à perdre du poids, les éduquer sur les maladies chroniques comme le diabète etc.

Mais la troisième équipe est l'équipe que l'on retrouve seulement dans les centres de santé communautaire, l'équipe de développement communautaire. Dans cette équipe, on retrouve des gens qui travaillent au niveau des déterminants de la santé pour garder la population desservie en santé. C'est là vraiment que les centres de santé communautaire se distinguent et qu'ils font tellement une grosse différence dans la vie des communautés là où ils sont installés. Il y en a présentement 54 et on en aura bientôt 76. C'était très bien, mais on n'a toujours pas un réseau à l'intérieur de l'Ontario qui permettrait de couvrir toutes les régions géographiques de l'Ontario. On les retrouve un petit peu ici et là.

Pour la région du grand Toronto, ils sont chanceux et la distribution est quasi adéquate. Mais aussitôt que tu vas un petit peu au nord, dans ma région, dans le nord de l'Ontario, il y en a un à Sudbury, un au Témiscamingue, un à Thunder Bay et un à Timmins. Il reste beaucoup de territoire dans le nord qui n'est pas couvert où il y a des gens qui n'ont aucun accès aux centres de santé communautaire. Pourtant, plusieurs de ces communautés-là ont des demandes de financement et que, on aurait pensé avec les nouveaux revenus de la taxe sur la santé, ça leur aurait été permis de financer. Mais non, on ne voit rien de cela. Dans la communauté de Elliot Lake, qui a une demande de financement depuis des années, dans la communauté de Copper Cliff, ça fait près de 10 ans qu'elles attendent pour avoir leur propre centre de santé communautaire. Ces centres-là ne se font pas financer et les gens continuent d'avoir des grands problèmes d'accès.

2050

Une autre chose importante à retenir face aux centres de santé communautaire : lorsque, pour une raison ou pour une autre, on est dans une région insuffisamment desservie, comme la région d'où je viens dans le nord-est de l'Ontario, souvent on a des pénuries de main-d'œuvre; les communautés ont de la misère à recruter des médecins. Avec un centre de santé communautaire, même si le médecin s'en va pour une période de temps, le centre reste là. Ton dossier médical reste là. Le restant de l'équipe est toujours sur place, ce qui aide les petites communautés, surtout du nord et rurales, à continuer d'offrir un certain niveau d'accès aux soins primaires pendant que l'on met les efforts de recrutement en place.

Avec les équipes de santé familiale, si le médecin s'en va, l'équipe part avec et il ne reste rien. Les centres de santé communautaire sont un modèle beaucoup mieux adapté pour répondre aux besoins des communautés rurales et du nord. Mais est-ce que la taxe santé a servi à en financer plus? Non, pas du tout.

My colleague mentioned an increase to the northern health travel grant. Of course, coming from the riding of Nickel Belt, a lot of my constituents use this program. The low increase to their budget was welcome, but it still falls way short of making sure that the people living in northern Ontario have the same level of access to tertiary and secondary care in the bigger centres as the people who live in southern Ontario. Did you know that the northern health travel grant gives you a whopping $100 to pay for your hotel room? Well, if you are from Nickel Belt and don't know your way around Toronto, trying to find a hotel room for you and your family while you have an appointment in a Toronto hospital is impossible. That means that if you're from a low-income family, if you're—God forbid—unemployed or on Ontario Works, you will have to subsidize that hotel room with money you don't have. It's the same thing with the mileage rate; it's really low. It makes it really difficult for people on a low income or fixed income to go to appointments in southern Ontario for services that are not available to northern Ontario.

This program needs to be looked at to better reflect the real costs to people who live in northern Ontario to access services that are not available in the north and are available in southern Ontario only. A hundred dollars a night for a hotel room does not cut it; it doesn't matter where you try to stay and what kind of a deal you try to make.

On parle du programme d'accès pour les gens du nord. Bien, ce programme rembourse les gens du nord 100 $ pour les frais d'hôtel. Cent dollars pour les frais d'hôtel suffirait peut-être dans le nord de l'Ontario, mais ce n'est pas dans le nord que l'on en a besoin; c'est à Toronto. Se trouver un hôtel qui va nous coûter moins de 100 $ par nuit est impossible à Toronto. Donc, si tu es d'une famille de travailleurs à petit salaire ou si tu es récipiendaire d'Ontario au travail ou d'un plan d'invalidité, bien, bonne chance. Cela veut dire que tu devras toi-même payer une partie des frais d'hôtel, et cela est souvent impossible.

L'autre chose, c'est qu'on ne t'offre pas cet argent-là à l'avance. Tu dois remplir un paquet de papiers, ton médecin doit signer ça, le médecin de Toronto et cetera doit signer ça, puis après cela tu attends. Tu attends et tu attends ton chèque, puis quand tu es bien tanné d'attendre, et tu es venu voir ta députée une couple de fois, tu attends encore six semaines puis tu vas recevoir ton remboursement, si tous les papiers ont été remplis comme il faut. Cela met les familles de petits salariés et les familles d'Ontario au travaille dans une position où elles ne peuvent pas bénéficier de ce programme.

On parle également de donner des licences aux médecins qui viennent de l'extérieur. Dans mon comté, j'ai justement une dame, une médecin, qui a pratiqué pendant plusieurs années en Russie, qui parle très bien l'anglais, qui est installée dans mon comté qui est sous-desservie des services depuis toujours. Il y a plein de petites communautés; j'ai 23 petites communautés dans mon comté. Les 23 petites communautés sont insuffisamment desservies. Elles sont presque toutes prêtes à lui offrir un poste, mais ça va prendre un autre deux ans avant qu'elles puissent avoir une licence pour pratiquer en Ontario. C'est un peu long pour des gens qui attendent, puis je ne dirais pas que c'est un des grands succès.

The new health premium was also supposed to help alleviate access to primary care by making it easier for IMGs, internationally trained medical graduates, to practise in Ontario. I was given the example of this lady in my riding who comes from Russia and is now a resident of Nickel Belt. She worked as a family physician in Russia for many years and is very qualified. She speaks English beautifully. She has embarked on this process of having her qualifications recognized by the government of Ontario. Well, going full speed ahead, it's going to take two years before she gets recognized. Those are two years where she won't have practised as a family physician and two years during which the 23 communities that make up Nickel Belt won't have access to her services, when each and every one of those communities is underserviced and has been underserviced for so many years.

We're also led to believe that if we pay this health premium, we will have more money for long-term care. Long-term care is made up of homes for the aged and nursing homes. This is basically a place where people go who need 24/7 supervision and care. Most people are elderly when they go to long-term care. They need hands-on care.

The health premium was supposed to help pay for more health services. Right now, the level of hands-on care in long-term-care facilities stands at 2.45 hours. Just work through the math in your mind a little bit. You get up in the morning and you need somebody to help you get out of bed, get out of your pyjamas and into your day clothes, and then you need somebody to help feed you your breakfast. We won't even talk about a mid-morning

snack at this point. You'll also need maybe another 10 or 15 minutes for somebody to help you go to the bathroom and wash up, maybe brush your hair and brush your teeth, and then maybe another 20 minutes or half-hour at lunchtime so that you can have somebody help you prepare your tray and help you feed yourself. Then you may have to go to the bathroom after lunch, so that's another 15 or 20 minutes. Then supper comes, and then there's the routine of going back to bed, and 2.45 hours doesn't add up anymore. You have workers in there, most of them women, most of them PSWs, who work so hard because their heart is there and they want to provide the best possible care to their residents but they just can't make it.

We've talked a lot about incontinence. A lot of residents have incontinence issues, which means that with proper incontinence management, if you bring them to the bathroom regularly, there's a good chance that the incontinence issues will be in check. But if you haven't got the staff to do this, then it all falls apart, and your dignity as a person goes out the window with it.

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On nous aurait fait croire que, avec la nouvelle taxe de santé, on aurait plus d'argent pour nos aînés qui sont dans des maisons de soins infirmiers; ce n'est pas le cas. En ce moment, on parle d'environ 2,45 heures de soins par résidant. Quand tu dis 2,45, c'est quand même assez bien. Mais quand tu passes une journée avec un résidant dans une maison de soins infirmiers, tu te rends compte qu'il y a beaucoup de soins et que ça prend du temps. On parle de la routine du matin : l'aider à se lever, à enlever ses pyjamas, à se brosser les dents et les cheveux, à se préparer pour la journée, aller à la toilette en se levant le matin, déjeuner, peut-être un snack dans l'avant-midi. C'est la même chose sur l'heure du dîner : préparer ton cabaret, t'aider à manger ton dîner, sans doute retourner à la toilette après l'heure du dîner. On parle également de la même routine qui se passe pour le souper : quelqu'un pour t'aider, quelqu'un pour ouvrir ton cabaret, le préparer, mais également quelqu'un pour t'aider à t'alimenter, puis peut-être une autre collation le soir, et après ça, te préparer pour le dodo. Mais tout ça ne se fait pas dans 2,45 heures.

On parle beaucoup d'incontinence. Dernièrement cela a fait les manchettes des journaux avec toutes sortes de « jokes » déplaisantes que je ne répéterai pas. Mais ce dont on a vraiment besoin si, en vieillissant, la personne commence à avoir des problèmes d'incontinence, c'est qu'on a souvent besoin d'amener la personne à la toilette plus souvent. Mais ça va dire qu'il faut quelqu'un pour t'aider. Si tu n'avais pas besoin d'aide, tu ne serais pas dans un foyer de soins de longue durée, tu ne serais pas dans une maison de soins de longue durée; tu serais chez toi. Donc, ces gens-là ont besoin d'aide, mais les femmes—parce que ce sont surtout des femmes qui travaillent là—n'en viennent pas à bout. Il y a tellement de choses à faire qu'ils vont au minimum—ils vont au maximum de leur capacité mais cela ne remplit pas le minimum des soins.

Toutes les familles ont écrit au ministère de la Santé, ont envoyé des pétitions pour leur dire, « On veut plus d'heures de soins et on a eu un gros six minutes de plus. Quelle déception. »

We would also be led to believe that this new health premium will help us pay for more home care. Home care is the type of care that people require to stay in their homes. I have been in the health care business for over 25 years and have yet to meet an elderly person who said, "Really, I don't want to be treated at home. I'd like to go to a long-term-care bed."

They want to stay home, surrounded by the people they know, surrounded by the things that they know and in charge of their own lives. But in order to do this, as people grow older and sometime frailer, they need a little bit of support.

This system of home care has been in shambles, has been doing really poorly since we introduced competitive bidding. Competitive bidding was supposed to bring the costs down; it did not do that. Sure, the for-profit corporation bid really low the first year to make sure that they'd underbid most of the not-for-profits that were offering quality home care services.

So the first contract looked pretty good. We seemed to be saving a lot of money. But that was the first contract. As soon as the second contract came about, we saw increases to the tune of 48% for the same level of care. Did the workers' wages go up 48%? I'll let you guess on that one. Not at all. Wages for those people—here again, mostly women—have continuously gone down, not up, their working conditions have deteriorated and they have no benefits. This is what competitive bidding has brought in.

Every three years you don't know whether you're going to have a job if you're a health care worker. If your company loses the contract and it goes to the other private for-profit company, then you get to reapply. Will they rehire you? Some of them get a job with the new one. Who would like to reapply for their job every three years? Who would like to start back at zero every three years, with no benefits? Chances are that you're doing the same work with the same client load, but for lower pay, less benefits and less mileage.

What kind of a system is that? If you don't treat your employees well, no wonder we have such a hard time recruiting people to work in that system. The new grads will go in, find the work is way too hard, and apply for anything else. As soon as they can get a job someplace else, they leave the home care system.

Is this the type of care we want to provide to the people who are aging at home, the people who need that little bit of support in order to stay in their homes? I don't think so, but this is what this lovely health premium helped us pay for. It helped us pay for a lower standard of care and lower working conditions. What a lose-lose situation.

La taxe sur la santé était supposée financer des programmes de santé, tels les soins à domicile. Les soins à domicile, c'est le type de soins qui aident les personnes à

demeurer chez elles pendant qu'elles vieillissent et qu'elles deviennent de plus en plus frêles. Moi, ça fait 25 ans que je travaille dans le système de santé, et dans toutes mes années de carrière, je n'ai jamais vu une seule personne âgée me dire, « Moi, vraiment, j'aimerais mieux aller au Manoir ou dans un lit de soins de longue durée que de rester chez nous. » Tout le monde veut rester chez eux. Ils veulent rester entourés des gens qu'ils connaissent, ils veulent rester entourés des choses qu'ils connaissent, et continuer d'être en charge de leur vie. Quand tu deviens plus âgé et plus frêle, des fois tu as besoin d'un petit peu d'aide pour faire ça. Puis c'est là que tu as besoin du système de soins à domicile.

Mais le système de soins à domicile a été viré sur la tête quand on a décidé d'avoir des compétitions. Les compétitions entre les agences qui offrent des soins à domicile, qui offrent n'importe quelles sortes de soins, ça ne marche pas. Quand tu est là pour offrir des soins, tu devrais travailler ensemble, en collaboration, pas travailler l'un contre l'autre. En travaillant l'un contre l'autre, en ces compétitions-là, la première année, les compagnies à profit ont mis des offres très basses, et plusieurs d'entre elles ont gagné de gros contrats, ce qui voudrait dire que les organismes à but non lucratif ont perdu des contrats, ont fermé. Dans ma communauté de Sudbury, une agence comme VON, qui était là depuis des années, qui était respectée par tout le monde, qui offrait des soins de « nursing » de très haute qualité, a perdu son contrat. Non seulement ont-ils perdu le contrat, ils ont dû déclarer faillite, pour que les compagnies à profit puissent avoir le contrat.

Bon, ça va avoir l'air beau. La première année, on était capable de couper les gages des travaillants. On était capable, apparemment, de sauver de l'argent. Mais trois ans plus tard, c'était le temps d'un autre contrat, et là, pour offrir exactement les mêmes services par les mêmes travaillants, ils demandaient 48 % de plus. Il n'y avait plus d'économies à faire là. Les économies, c'était fini. Les économies, c'était pour gagner le contrat. Une fois qu'ils avaient le contrat, puis que les agences à but non lucratif avaient dû déclarer faillite, qu'ils ne pouvaient plus eux-mêmes compétitionner, là, les prix ont commencé à augmenter. Quarante-huit pour cent, c'est une grosse augmentation.

Est-ce que vous pensez que les travailleurs dans le domaine des soins à domicile en ont profité, de ce 48 % d'augmentation? Pas une miette. Les salaires dans les soins à domicile continuent de dégringoler et de diminuer d'une année à l'autre. Les conditions de travail s'empirent d'une année à l'autre, et le remboursement du kilométrage empire d'une année à l'autre.

On a un système, et à tous les trois ans on prend ce système-là, on le vire en envers complètement, on dit à tous les employés, « Vous venez de perdre votre job. Vous allez devoir demander et appliquer pour votre même job avec les mêmes patients, avec une autre compagnie qui va vous payer moins cher, qui ne vous offrira pas d'avantages sociaux, puis on va vous donner moins de cents le kilomètre. » Quelle sorte de système est-ce qu'on a là? Est-ce que c'est vraiment le système que l'on veut pour les gens qui ont besoin des soins à domicile ? Moi, je ne pense pas. Mais c'est ce qu'on est en train de leur offrir.

Ça fait que les gens qui offrent des soins à domicile ont beaucoup, beaucoup de difficultés à recruter. Ils ont beaucoup de difficultés à recruter parce que la plupart des gens qui travaillent dans le système de soins à domicile, aussitôt qu'ils peuvent se trouver une job ailleurs, ils le font, parce que la job ailleurs va payer mieux, elle va avoir des avantages sociaux, puis on va te donner un petit peu de respect. Le système de compétition n'offre rien de ça. Il faut s'en débarrasser, et au plus vite. Si la taxe santé ne servait qu'à faire ça, les néo-démocrates l'appuieraient.

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The budget also provided monies for hospices. Hospices offer end-of-life care in a very dignified way, and there are a number of them under way right now. One in my community, Maison la Paix, is presently building a new hospice. Maison la Paix has put in a lot of effort to mount a really aggressive fundraising campaign, and they were very successful to date and were able to raise a lot of money. What did that mean? That meant the McGuinty government gave them only half a million dollars for the hospice. Go to any other communities—maybe North Bay, maybe Sault Ste. Marie—that are also in the north that did not put the effort into fundraising that Sudbury did and you'll see that they got $2 million and $1.5 million. So how does the McGuinty government thank the community that has really supported their hospice? They give them less money.

My hospice in Sudbury will do well because it has a group of good people who work really hard, but it won't be thanks to the health premium and it won't be thanks to this government, which didn't see fit to give them an amount of money proportionate to the number of beds that were allocated to them.

J'aimerais vous parler des soins des hospices. On parle de soins palliatifs; on parle d'une maison où les gens qui sont palliatifs peuvent aller vivre leurs dernières journées. À Sudbury, nous avons un tel hospice qui s'appelle Maison la Paix, qui est présentement en construction. Maison la Paix a mis beaucoup d'effort pour faire une levée de fonds qui jusqu'à date a eu beaucoup de succès. Mais qu'est-ce qui leur est arrivé? Quand les fonds sont venus pour payer pour les services d'hospice, pour être à Sudbury, ils ont reçu un demi-million. Moi, j'ai regardé ça et je me suis dit, « Bon, mais c'est pas pire ». Mais là, tu commences à regarder ailleurs puis là tu vois bien que l'hospice à North Bay et celui de Sault Ste Marie ont reçu des montants beaucoup plus gros. Est-ce que c'est parce qu'ils sont beaucoup plus gros? Non, pas du tout. C'est qu'eux n'avaient pas fait autant d'effort pour faire une levée de fonds. Ça veut dire que lorsque les communautés se sont engagées pour soutenir leur hospice, le gouvernement McGuinty les a punis en leur donnant moins d'argent. Ça, ce n'est pas très encourageant pour personne. Ça ne montre pas non

plus des qualités de leadership, où tu encourages et tu finances les services de façon proportionnelle au nombre de lits dans chacun d'eux.

I'd like to talk about the wait time strategy. This is one of the pillars of the health care system, something that gets lots of coverage in all the media that seems to be so good. Apparently this health tax is going to help us to fund some of this wait time strategy.

First of all, the wait time strategy only applies to a few procedures. We've named some of them: cataract surgery, hip and knee replacement etc. Some of those procedures have decreased the amount of wait time, but there's a price to pay for this. The price to pay is that if you are not a standard case—if you have a language issue because you're a new immigrant, if you have mental health issues and we may need to spend a little bit more time with you, or maybe you have an aggressive behaviour, which means we will need to put in a little bit more resources—if you happen to be one of those, then we don't want you. We don't want you because we're not going to make any money if we take you. If you're a healthy, English-speaking Ontarian who can be in and out of there quickly, sure the wait time strategy will help you. But if you happen to be a new immigrant, somebody with a mental health issue or somebody who needs a little more care or more resources, the resources put into those surgeries are not going to be enough. As hospitals struggle to balance their budgets, they start to look at those clients as, "Maybe that one will go to the bottom of the list, because we're not going to make any money"—because now we're not funded on a global budget where you decide who needs care based on the needs of the person; you now have this new financial formula that says, "You get that much money. It doesn't matter what the needs of the person you're going to serve are." So what do hospitals do? They say, "With that much money, I can serve that kind of client. And if you don't happen to be that kind of client and you're going to cost me more than that amount of money, then maybe we're busy or I hear my mother calling me. Anyway, you're at the bottom of the list."

This is not the kind of care we want in Ontario. This wait times strategy is a way to pay for procedures on a per-procedure basis and it goes against what medicare is all about: that you provide care based on the needs of the person, not on the amount of money the government is willing to give you for that strategy.

Funny, things like children's mental health services are not on the list. Addiction counselling is not on the list, either. You'll never see women's health on the list. And children's treatment centres? I don't think so. The procedures that have some sex appeal and strong lobbying behind them make it to the list; the rest of them don't.

This is not the kind of health care we want in Ontario. We want the health system to treat people based on their needs, not on how fancy their diseases or procedures are.

I want to talk a little bit about hospitals trying to balance their books. The new health care premium bringing more money into health care led us to believe that there would be more money to pay for hospital services. Well, this is not the case. As my colleague has mentioned, over 60% of the hospitals in Ontario don't think that they'll be able to balance their budgets.

In my riding, I had a constituent come to me and say, "I hurt my shoulder a year or so ago. I was referred to physiotherapy and they called me within a couple of weeks." He happened to hurt the other shoulder in August of this year. His physician referred him to physiotherapy, and he has been on the waiting list ever since because the hospital, in trying to balance its books, has downloaded physiotherapy services into the community. If you go into community physiotherapy, you have to pay for the service. It will only be free if you go to the hospital. But the hospital has kept so few of those physiotherapists on staff that the waiting list now stands at 400. He has been on the urgent waiting list for the last eight months, and he now stands at 167 on the list. By the time he's seen, his shoulder will be frozen and he will need way more care than if he had been seen in a regular timeframe.

This health tax has not made anybody healthier. It has been taxing the poor and the low-income families to the detriment of their own health and their own pocketbooks, I would say. It is a regressive tax because it taxes the poor, the low-income and middle-income families more than it does the people making $100,000 and $200,000 a year.

This needs to go to committee because the McGuinty government needs to hear what it means to the people of Ontario to pay that tax. It is so regressive; it is unfair.

The Deputy Speaker (Mr. Bruce Crozier): Further debate?

Mrs. Carol Mitchell: I will be splitting my time with the member from Thunder Bay–Atikokan.

I can tell you that it really is my pleasure to rise tonight and to speak about the premium. But before I do that, I want to just go back in time to 2003, when we became the government.

One of the things that I did in my riding of Huron–Bruce was have budget consultations. We held roundtable discussions about how the people of Huron–Bruce wanted their tax dollars spent. At that time, we knew that the previous government had left us with a $5.6-billion deficit, and I can tell you that the people from Huron–Bruce were shocked, because that certainly was not what they were told by that party prior to the election.

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But what the people of Huron–Bruce told me was that they were prepared to pay a dedicated tax that was targeted specifically, be it to health care, be it to social services, be it to infrastructure. They were prepared to do that. I took that back to Toronto after numerous round table discussions with my constituents and shared that information, and then the budget came forward. I can tell you that I went back to Huron–Bruce and was very clear on what the health tax—the premium—would be going towards.

I know that the members in the House this evening want to know: How was that money spent in the riding of Huron–Bruce? I can tell you that this is one riding in all of the province of Ontario, but the difference it has made in my riding is absolutely incredible. We know 500,000 people today have access to a primary health care provider, that being their family doctor. But in the riding of Huron–Bruce, what does that number look like and what does that represent? Within the riding of Huron–Bruce, there are seven new family health teams.

Hon. Deborah Matthews: Seven?

Mrs. Carol Mitchell: Seven. Just to get a sense of it, I just want to talk about one for a minute, and it's called the Brockton family health team. The Brockton family health team has offices in Mildmay, Paisley and Walkerton. In Paisley, they have never had a clinic, not ever. This is a village that has never had the ability to bring services to their village. Mildmay—a brand new clinic. They had such a wonderful response to the fundraising that not only did they get their money for the clinic but they also received so much money in fundraising dollars that they were able to provide more services. That's just one of the seven, but I wanted to share that good news.

Then I look at the redevelopment of our long-term care. "What's happening in Huron–Bruce?" you want to know. Well, I can tell you that the Blue Water Rest Home in Zurich had been working for over a decade to get the plan to go forward to redevelop for these much-needed long-term-care beds. It's been delivered.

When we talk about redevelopment, our hospitals, I have eight hospitals within the riding, so we know what we speak of when we talk about hospitals. Of those hospitals, do you want to know how many are being redeveloped right now, because I know the comments made by the opposition and the comments made by the third party—I mean, one says get rid of the tax; the other one says the tax is not enough. But in my riding, what did that mean? Exeter hospital, Kincardine hospital, Wingham hospital, Goderich hospital: Of the eight, four are going forward with redevelopment.

I want to share this story. In the previous government, how many hospitals do you think were threatened with closure? About half. Those are the hospitals that are going forward. That's the difference it has made in the riding of Huron–Bruce just with redevelopment.

Let's talk about cataract surgery. We know that for cataract surgery today, the people of Ontario are experiencing a 61% reduction in wait times. I know that all the members want to know what that means to the riding of Huron–Bruce. What that means is, we provide cataract surgery at another of my hospitals, Clinton hospital—

Interjection.

Mrs. Carol Mitchell: Yes, you're very familiar with that hospital. They have been able to triple the number of cataract surgeries they're doing in our hospital, Clinton. When I think about that—because I can remember, when I was the head of the municipality, we were burning in barrels to save our hospital, with the previous government, just to raise the awareness of how important it was. I know sometimes there are comments from that side of the House about the premiums and how those dollars are allocated. I think we need to remind people of what that really means to the people of Ontario, what that means for someone who lives in the riding of Huron–Bruce.

But there's more good news. Goderich hospital, as I told you, was also going through a redevelopment. They also have approval to move forward with a CT scanner. Huron county is the last county in the province of Ontario to receive a CT scanner. I know that all the members of the House want to know how much money has been raised in Goderich to pay for that CT scanner, and I can tell that you $4.2 million has been raised in the town of Goderich.

When we talk about what difference the health premium makes, we can think about all the examples specifically that have happened in Huron–Bruce. I'm very proud of the investments that have been made throughout Ontario, and specifically in the riding of Huron–Bruce, but I am also very proud that the review that will happen will be through the finance committee and there will be discussion on it. We committed to do it and we will go forward with it. As we did through the budget, we will also see the review about the health premium go forward.

I want to thank you, Mr. Speaker, for allowing me to share all the good news from Huron–Bruce. And now, the member from Thunder Bay–Atikokan.

Mr. Bill Mauro: I want to thank the member from Huron–Bruce for sharing her time and for that rousing introduction. I appreciate it.

I listened intently to the speakers from the other parties, as well as the member from Huron–Bruce, and I thank them for their comments. I think it's rather important for me, though, to put on the record what I consider one or two significant results of the introduction of the health premium in my riding.

In the election of 2003, when I first ran provincially, it may come as a surprise to some that the Thunder Bay Regional Health Sciences Centre, the main hospital in my riding, which services a population of about 250,000 people in northwestern Ontario, heretofore was never able to provide angioplasty services. It was 2003 and angioplasty services were not able to be provided in a hospital that serviced a region with 250,000 people in it. On an annual basis, anywhere from 400 to 500 people who required that surgery had to leave Thunder Bay and northwestern Ontario and travel to southern Ontario, to communities like Ottawa, London, Toronto and Hamilton. A significant cost would accrue back to the taxpayers of the province to have it done, and also a significant cost would accrue back to not only the individuals who had to have the service but to their families who wanted to travel with them to support them during an extremely emotional time.

That was a commitment I made in 2003, and I stand here today very proud that through the health premium, through our government's investment of significant financial resources into the health care sector, we have announced and have begun providing angioplasty ser-

vices at our Thunder Bay Regional Health Sciences Centre. It's servicing, in fact, an entire district. Without the introduction of that premium, I'm not sure if we would have been able to meet that commitment and provide that incredible service.

The second thing I'd also like to leave people with tonight that I think is a direct result of the introduction of that premium is a commitment by the health minister, just confirmed here, that was a commitment I made in the election of 2007—to try to see what we could do to fund a prostate-specific antigen test for men. I introduced two private members' bills on that issue. As many will have heard here not long ago, the Minister of Health has now committed to seeing that program up and running in very short order. It's another significant move forward on the part of our government, two major pieces that I've outlined, and as the member from Huron–Bruce and others have mentioned, there are significant results all of us can list that are tangible, real, and help the people in their ridings—not just members on this side of the House, but I would expect members on the other side, on the opposition benches as well.

So while it may be controversial for some in the other parties, the premium has shown some incredible, tangible benefits to the people in most, if not all, of the ridings in this province. I'm happy that it's there and I hope we keep it there.

Debate deemed adjourned.

The Deputy Speaker (Mr. Bruce Crozier): It being 9:30 of the clock, this House is adjourned until 1:30 of the clock on Wednesday, April 9.

The House adjourned at 2130.

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