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Wednesday 4 June 2008

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Mercredi 4 juin 2008

Standing Committee on Estimates

Ministry of Health
and Long-Term Care

Comité permanent des budgets des dépenses

Ministère de la Santé et des Soins de longue durée

Chair: Tim Hudak
Clerk: Sylwia Przezdziecki

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Hansard Reporting and Interpretation Services
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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON ESTIMATES

COMITÉ PERMANENT DES BUDGETS DES DÉPENSES

Wednesday 4 June 2008

Mercredi 4 juin 2008

The committee met at 1611 in room 151.

MINISTRY OF HEALTH AND LONG-TERM CARE

The Chair (Mr. Tim Hudak): Good afternoon, folks. I'm pleased to call back to order the Standing Committee on Estimates for its first day of consideration of the Ministry of Health and Long-Term Care. We welcome the Honourable George Smitherman, Minister of Health, back to his favourite committee, the estimates committee. I know the minister enjoys it; we always enjoy having the minister. We have Deputy Minister Ron Sapsford as well. Deputy Minister, welcome back to the estimates committee. It's good to see you again.

Just an opening comment: We have 10 hours of hearings on the Ministry of Health and Long-Term Care. Minister and Deputy, I think you understand that we do ask you to monitor the proceedings closely for any questions or issues that you cannot answer at the time. That does happen from time to time; we understand that. I trust that the deputy minister has made arrangements to have these hearings monitored so the ministry can respond accordingly when they have that information at hand. As always, we have our intrepid researcher here, Elaine Campbell, whom you can compare notes with after each committee meeting to make sure that the questions that require follow-up are clear.

Just to remind folks of how this works, the minister has 30 minutes to make his opening comments, followed by 30 minutes for the official opposition, 30 minutes for the third party, and then, traditionally, 30 minutes for the minister to wrap up. The way the clock will work today is, that will take us to about 10 past 6. So the minister could use 20 minutes to wrap up, or if you want to stand down the additional 10 minutes to our next meeting, you can choose to do that as well. Given that there is an occasion that many members want to go to this evening, I'm going to recommend that we try to end by 6 p.m.

Hon. George Smitherman: With your good memory, you might know that I don't really want to go to that occasion. Nevertheless, I'd be happy to stand down the balance of my time to the first 10 minutes of the next time that we have a chance to meet.

The Chair (Mr. Tim Hudak): Very good. I will now call vote 1401. Of course, members know that after the initial round of 30 minutes, we divide up the time equally in 20-minute segments among the three parties.

Minister, the floor is yours. You have 30 minutes.

Hon. George Smitherman: Most people wouldn't say this and be believable, but I hope you believe me when I say it's nice to be back. We were disappointed last year when the ministry didn't get to come to estimates and present some of the progress we've been able to make and to address the questions that invariably come.

The Chair (Mr. Tim Hudak): You did it for the Premier's office, though.

Hon. George Smitherman: Yes, that's right. Now that you mention it, I remember that.

I don't have a prepared text per se; just a few speaking notes. But one thing that we have prepared for the benefit of members is this document, Strengthening Health Care for Ontarians, and in a variety of points, I'll be referring to specific pages. I came to the conclusion, because the Ministry of Health budget that's before everybody is about $40.4 billion, that sometimes it's helpful to try to distill it down to a bunch of the key issues that are very, very relevant to all of us and to our constituents. For sure, what that gives us the opportunity to do is to present substantial results that are reflected in these one-pagers.

From the very first day, in October 2003, that I gained the privileged role as Ontario's Minister of Health, I concluded that the theme of continuous quality improvement was what is necessary for the appropriate approach to health care. There's absolutely no doubt that for all of the reformist zeal and transformative initiatives that we've implemented, there are many areas in health care where we can all acknowledge that there's more work to be done. I'm really excited about the opportunity in this session to talk about our government's vision for health care over the next few years.

One of the things that I really think has begun to take root in our health care system is a better concept of patient-centred care. At the heart of it, I try to remind everybody that the patient isn't just the individual whom the service provider delivers support to; the patient is actually a shareholder. The public health care system is owned by 13 million Ontarians, and the obligation on their behalf is one that we take very seriously.

We've done a lot of transformative things in health care, and one of the things we've done is to adopt what Roy Romanow said. He once said that accountability was the missing sixth principle of the Canada Health Act. I think that in a variety of ways, through transparency as a means to accountability, we're dramatically enhancing

the amount of access that people have to information about the performance of their health care system.

Local health integration networks have emerged in a way that allows a conversation about health care to take place in a local community and in a local context. Important decisions of the boards of LHINs will be taken in the full sight of the public.

The wait time initiative gives Ontarians the opportunity, with a click of a few buttons, to gain access to a bevy of information—which is in the midst of expanding dramatically—about the performance of a wide variety of health care initiatives.

Patient safety measures, like those that I've had a chance to speak about in the Legislature quite frequently over the last several weeks, will dramatically enhance the amount of information that Ontarians have about how their health care system is performing from the standpoint of their safety.

You can look forward to initiatives that the Ontario Health Quality Council will be initiating that will substantially enhance the capacity of the health care system to measure performance, not just on the outcome, not just on the health experience, but also on patient satisfaction. I think that we're going to work very hard to give greater measure to the voice of the public in our public health care system.

At the heart of the things that I've been saying to everybody is that in a public health care environment, where there is no profit-and-loss statement at the end of the year, the confidence that the public has in their public health care system is the dividend payment. That's the measure of how we're doing. I think that's why we're very dedicated to enhancing the capacity to measure the satisfaction of patients in areas like home care. Clients in home care will have an enhanced opportunity to influence decision-making on the basis of the quality of the care that's provided; likewise, this will be occurring in long-term care, and also with respect to the patient satisfaction rankings for the performance of Ontario's hospital emergency rooms. Any successful business knows that to succeed, you have to listen to your customers. Well, for all of those who are privileged to work in a public health care environment, we need to acknowledge that patients aren't just those to whom we deliver care; they're actually our bosses. They own the public health care system, and we have more work to do to make sure that we're all operating with that perspective firmly in place.

I believe that the actions we've been able to take have instilled hope and convinced Ontarians that the improvements that they seek can be realized, that our collective aspirations are within reach. But I don't pretend on this point. I don't offer a simplistic bromide that says that everything is hunky-dory. There are lots of areas in our health care system where improvements have been made, and there are many areas where much more progress is still required. I think that this estimates process will give us a fantastic opportunity to speak about those things.

I think most people would share the vision of a health care system that wants to help people stay healthy, delivers good care to them when they need it and will be sustained for future generations. Since 2003, our government has taken some awfully substantial steps to strengthen our health care system and to instill greater confidence and to work in a fashion that can sustain it into the future.

For sure, now in my fifth year as Minister of Health and Long-Term Care in our province, I've had a chance to deal with a lot of numbers, and one of those that I think is really impressive, insofar as it underscores the extent to which Ontarians believe in their public health care system, is that our spending on health care in 2003 was $29.3 billion and this year it's about $11 billion more. Spending in the health care sector for this year is proposed to be $40.4 billion, rising to $42.4 billion in 2009-10 and $44.7 billion in 2010-11. This demonstrates that even in challenging economic times, the commitment of the government to continue to support the things that people call for, which are enhancements to their public health care system, is there.

We remain very firm in the idea that the health care system that we all aspire to is within our reach. That's in part why we've distributed to members of this committee this orange document. We really think that the discussion with respect to health care, because it's so big and so much of it is clinical in foundation, sometimes runs the risk of leaving the public out of the conversation because the conversation might be about 1,000 things.

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But what I really want to let the committee know, and as I've had a chance to speak about publicly over the last little while, is it will take 1,000 different initiatives to make the progress that patients want to see in their public health care system. But our desire is to make sure that we focus key improvements in areas where the public really understands and where the public really has expressed a substantial desire to see improvement. We can fix 1,000 things in health care over the next three or four years, but if we don't create a better capacity to provide the services people want in our hospital emergency rooms and if we don't deliver family health care for all, then we will fall short; we will not meet the full test of the confidence that the people desire, demand and deserve to know about their public health care system.

We have two overarching priorities: to continue to reduce wait times, with a particular focus on emergency rooms, and to deliver family health care for all. I'll speak more about the family-health-care-for-all subject in just a minute.

I want to talk about emergency rooms. All too often, for Ontarians, it's been a door through which they go to gain access to health care—not always, if we're honest about it, the most appropriate place to go for care.

This week, as an example, there's been a little bit of a discussion—a debate and some media interest—on the issue about whether, in the future, pharmacists might have a broadened scope of practice that would allow

them, as an example, to renew prescriptions. We know in Ontario today that tens of thousands of people a year go to hospital emergency rooms to have prescriptions renewed. We all understand that that speaks to inadequate access for those patients. We also know that it speaks to inappropriate use of emergency rooms—not the best use of an asset that is designed to be there to address very urgent circumstances.

In order to make the improvement that we seek in our hospital emergency rooms, which had 5.6 million visits last year—about half of those, about 2.8 million, unique individuals. That's an awful lot of Ontarians, especially when you think that most people, at least from my experience, go to a hospital emergency room with at least one other person in support and sometimes entire families in tow. I think that's why it's very important that when we design a focus on improving the performance of hospital emergency rooms, we recognize that much of what must be done to improve that performance isn't about things that are taking place in the emergency rooms at all.

We have supporting strategies that give us the confidence that we can achieve a better result, things like our aging-at-home strategy, which we'll launch in just a few weeks and which I'll talk about a little bit more in a minute. To do a better job to manage the chronic diseases of Ontarians is to say that if we do a better job of focusing all of the resources and capacity that we can on those individuals, who by the nature of their chronic disease demand, deserve and require greater support, we can do that proactively and take pressure off our emergency rooms. If we do a better job in the community of supporting our Ontarians who are experiencing hardship associated with mental health or with addiction issues, similarly, we can get them better care and we can take some of the pressure off our hospital emergency rooms. Even as we admit that it's a door that many people go through in search of care, we must be honest in acknowledging that not all of the care that is sought there makes for the most appropriate place. We can do better in many ways. And the investments that our government contemplates in this year's estimates really do underscore how confident we are.

Our confidence too is certainly driven by the fact that we continue to have extraordinary leadership, gutsy leadership, from Dr. Alan Hudson. The Canadian Medical Association—which is not always, I'd say, a big fan of the health care policies of the government of Ontario—did give our team that has led the wait times initiative the best rating of any province in the country. We're enormously grateful to Dr. Hudson and we're grateful to the team of people.

On this point about team, what I know for sure, as a health minister with the perspective of now well over four years in this job, is that the health care system today has thousands and thousands of motivated and inspired individuals who are providing leadership in a wide variety of settings. On wait time initiatives, we've used coaching teams that have engaged physician leaders, administrative leaders and nurse leaders to work on process, flow and all of those things that are necessary to produce the kinds of results that we have produced. When you look inside this report and see all the lines related to wait times headed in a good direction, you can gain greater confidence that bringing this award-winning team and the kind of cultural approaches that we've used to the issues with respect to our emergency rooms holds great promise for substantial progress.

Last week, we put $109 million of new resource into this battle to reduce wait times in hospital emergency rooms. I think it's noteworthy that of that $109 million, a very substantial portion, certainly the majority of it, is actually allocated outside of the hospital emergency room in building up the capacity of home care to support more seniors by giving an increased number of hours, as an example.

In addition, we're focusing some resources in a pay-for-performance model, by which I mean to say, you don't get to keep the dough if you don't improve your performance. We're going to work with a starting point of 23 hospital emergency rooms tending to be amongst the highest-volume emergency rooms, many of them being academic health science hospitals, where the performance, based on the waits that people are experiencing, really does call for some substantial improvement.

A major factor, of course, in long emergency room wait times is what has become well known in the vernacular of the health care world as the ALC patient—alternate level of care. To say it clearly in language that people understand, that's a situation that occurs when an individual is in an acute care hospital bed and would be better served somewhere else. It's costly for the health care system. It's also very discouraging for the health care workers. It's often discouraging for the individuals who are in that situation. We have lots of work to do in this area.

Luckily for us, under Dr. Hudson's leadership, we've been able to acquire the assistance of Kevin Smith, the chief executive officer of St. Joseph's hospital in Hamilton, with connections to St. Mary's in Kitchener. He's going to work very specifically on the issues of alternate level of care. Of the $109-million investment that we made last week, a very substantial portion of that is to enhance the capacity to provide care for individuals in the most appropriate setting. Sometimes, it's about the steps that we can take to enhance the supports for individuals, who are exiting the hospital and preferably, going back home. In other cases, it's about the initiatives that we can make to support people where they are, in some cases to stabilize them in their home environment, preventing a transfer to the emergency room in the first place.

If we think about our population of vulnerable individuals in long-term care, I think the average age is about 83 or 84 years of age. This is not an age group of a vulnerable population already in long-term care—suggesting, of course, that they had some additional need. Transferring those individuals to hospital emergency

rooms is very often a hardship for them and creates great difficulty for the hospital emergency room to deal with, as very often they're grappling with a patient not well known to them who may have several underlying circumstances that must be diagnosed and addressed. We think that we can do better by supporting those individuals in the long-term-care home environment. That's why there's an element of that investment from last week that focuses very specifically on that.

I think one of the greatest pieces of policy promise in the health care agenda in the province of Ontario is the aging-at-home strategy. I just want to give a shout-out to all of those people, the thousands of people from the LHINs and from communities all across Ontario, who've engaged in dialogue.

There are a lot of exciting new initiatives that within just a few weeks we'll be launching in each of Ontario's 14 local health integration networks, all on the premise that we can do a better job to support our loved ones to age in the place that they know best and where they know love best, which is their home.

As a Minister of Health, I took a drubbing very early on—some people would argue, pretty much every day—but one of the things that I learned right from the clear expressions of seniors in the province of Ontario was that for them, the destination point in their minds is not long-term care. People acknowledge, of course, that it may be necessary and that in certain circumstances long-term care may be necessary for them. They don't want to see government acting in a way which assumes that that is their destiny. The aging-at-home strategy, in a vigorous way, embraces this independent streak: the desire to enhance the capacity of our seniors to live out all of their days, if possible and as preferable, in their home environment with dignity and with independence.

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I mentioned a moment ago that creating more capacity for home care is one part of that strategy, but the aging-at-home strategy will be about a whole bunch more: about helping to reduce the barriers that seniors may experience to stay in their own homes. One small but very powerful example of this is in our initiative to buy 100 Dodge Caravans and to place them at the disposal of community agencies, all across the province of Ontario, augmenting many existing drive-to-appointment programs. We're going to create the capacity for 135,000 more transfers between a resident's home and the kind of appointment they may need. This is one very good example of an aging-at-home initiative, of which there will be 260 across the province, that is really about knocking down the barriers. Some of them are about additional health services for sure, but some of them are about the things that you need to be healthy in your home environment. For some it's assistance with bathing, for some it's assistance with cleaning and for some it's assistance in going to pick up a week's worth of shopping or Meals on Wheels. There is a wide variety of the kind of supports that have the capacity as well to leverage the love of community providers and the volunteers who work alongside them.

In the next four years, I'm enormously proud that $1.1 billion in new resources will be dedicated to the idea that our seniors deserve the opportunity to live out all of their days with dignity and independence in the home that they know now. I just want to encourage everybody to keep their eyes open, because we're going to have very exciting launches all across the province of Ontario.

One thing which is a phenomenon associated with the local health integration network initiative is that LHINs engaged with their communities have chosen priorities, and they're not all identical. I think that the exciting part about that is that it sets us up for what I call a virtuous competition, where the people in Champlain LHIN may uncork a novel idea and the people in Waterloo–Wellington will say, "Hey, why not us?" The good news is that in the next two fiscal years, aging-at-home resources will continue to increase, so that an idea that is initiated or piloted in one part of our province can be grabbed hold of by the leaders in other parts of our province. That's a phenomenon that's possible because local health integration networks have come to life in our province.

When we look at combining the power of the aging-at-home strategy with the enhanced resources for home care that we announced last week to address the alternate-level-of-care patients, we really feel that we're getting at the heart of the matter, which is offering care to people in the most appropriate setting.

As the first overarching priority, we're going to drive results and enhance the performance of Ontario's hospital emergency rooms. I say this with confidence, but I'm not misunderstanding for one second; this is a difficult task and this is a task that people have grappled with to varying degrees of success. But we've got great leaders out there, and people have initiated models that give us a lot of confidence that we can make substantial improvements not just in the amount of time that people spend there but in the experience that they have while they are there. Patient satisfaction is not merely a measure of time; it's qualitative and quantitative. We seek to make improvements on each of these two parts of the experience.

The second overarching priority is a comprehensive family health strategy that gives us the chance to deliver family health care to all of those in Ontario who are looking for it. With a 13-million person population in Ontario, at any given time there are a few people who may be conscientious objectors to western medicine or there are some young folks who maybe aren't active in the search for a family doctor. But what we know for sure and what we've seen great strides around is that the number of people who are actively looking for a doctor is lower than the number of people for whom we got a doctor in our first term of office. That's why we're confident that over the next four years we can deliver family health care for all.

About two weeks ago, the Ontario Health Quality Council put out a report that I would encourage members

to look to. If they have questions, we can certainly use some of our time around that. It said that there are 400,000 people in Ontario who are actively looking for a doctor. That's a lot of people to be without a doctor, but consider that just three or four years ago, when we were discussing things like this, numbers like 1.6 million and 1.7 million were used. We know that with the strategies we have developed—like family health teams, which have provided care to almost 200,000 who didn't used to have a doctor; additional community health centres; our nurse practitioner-led clinics; and working with the physicians in Ontario, 83% of whom took on new patients last year—we've made great progress, and that gives us the confidence that over the next four years we can unlock what has been a challenge for some people in Ontario.

There is strong evidence of the results of our partnership with the Ontario Medical Association. The people of Ontario have contributed very substantially to enhancing the compensation rates for doctors in Ontario, but the great news for the people of Ontario is that alongside the increased compensation for the doctors was that 650,000 more Ontarians gained access to one. That's why we believe that we can deliver family health care for all.

Our confidence is also based on the fact that our campaign platform, and now our government's budget and the estimates that are before you, give us additional capacity for the creation of more family health teams—50 of them—and 25 nurse practitioner-led clinics targeted at those communities in Ontario that have the greatest burden with respect to people being without access to family health care.

In the slides, like the one that you can find on page 2, there's a one-pager on nurses, and there is a one-pager on page 1 on doctors. These charts show very clearly, if you look at the number of doctors practising in Ontario, that each and every year we've seen increases. If we look at the next chart in terms of the number of doctors—that is, those who will be graduating—the projection is for increases. If we look at the number of international medical graduates entering the Ontario physician workforce, what you see is that we've got tremendous additional capacity over what we had when we first came to this role five years ago.

If we look at page 2, on the nursing workforce, we see very substantial improvement in the percentages of nurses working full time. In the pie chart, we see that Ontario's nursing graduate guarantee has been one of the most remarkable program launches ever, and being copied by many jurisdictions around the world. Only one or two places in the world had even initiated such a graduate guarantee for nurses. We had all heard that sad story where we need nurses and then newly graduating nurses wouldn't transition to opportunities and would go looking to other jurisdictions for them. I don't pretend that the whole situation is perfect, but last year, with the new-graduate guarantee, 86% of those nurses gained access to full-time employment.

We know that we can do better, and we especially have to do better for registered practical nurses, who, in the field of nursing, did not experience as much success with the program as the registered nurses do.

If we look to the other chart, "Nurses Employed in Nursing in Ontario," this is data supplied by the College of Nurses of Ontario's annual membership stats. There is no perfect measure of any of these nursing numbers, but this is widely viewed to be one of those that is most accurate. It makes no argument but that there are more nurses practising in Ontario, and over the next several years we have $500 million to invest towards hiring 9,000 additional nurses by 2011-12.

The most revolutionary change that we've seen over the last few years is the evolution to team-based care. We have, in my critic from Nickel Belt, a member who was once the executive director of a community health centre. Our family health team initiative, which has seen these remarkable family health teams come to life in all parts of the province, is built on many of the kinds of ideological or clinical underpinnings of the community health centre model, based on the idea that a team of people working together is better for the team than to be working in isolation and better for the patients insofar as offering them the kind of comprehensive care that can really enable the best-quality health care.

I just want to say that when we first launched family health teams, a lot of people said, "These things aren't going to be successful. Doctors don't want to practise in them." To the contrary: We're overwhelmed, really, with the requests for more family health teams, and also, from those which have already been launched, for them to continue to grow. We're just so grateful that the physician community in our province has responded so positively and, alongside allied health professionals and nurses, is making such extraordinary progress.

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In conclusion, and in anticipation of the opportunity to listen to or perhaps to answer some questions, we look forward to the next nine and a half hours to talk about the things that we've done, the progress that we've made and the resources that are embedded in our budget to allow us to deliver, on behalf of Ontarians, two things that are really important to them from the standpoint of the confidence that they enjoy in our public health care system: reduction of wait times, with a particular focus on emergency rooms, and family health care for all.

The Chair (Mr. Tim Hudak): Minister, thank you very much for the comprehensive introductory comments. We will now proceed with the official opposition. You have 30 minutes of time.

Mr. John O'Toole: Thank you, Minister, and your staff, for a very comprehensive, free-moving introduction to probably the most important—in fact, it is the most important—issue facing all Ontarians.

I first want to express my regrets or apologies that our critic, Elizabeth Witmer, who has served as a very caring health minister as well, isn't able to be here today and reluctantly has asked me to pass on these remarks here. She's actually given me a few questions.

I listened to you, and you mentioned several things that are quite pertinent to each member here, because

health care is the number one priority, regardless of the ideology you represent, the community you represent, the area, the geography—whatever. It's number one, not just in how much it takes to finance the right things, but also in how it affects our lives day to day, whether it's organ donation, out-of-country service—you name it. The rising costs of things are something of a challenge, and, more recently, the technology question as well, the health privacy issue—huge. You'd have to have Ann Cavoukian come in here to talk to us about that.

But I want to talk about my riding of Durham. I want to express a great deal of thanks to the community I represent. Last night, I attended a meeting in my riding of Durham and heard many of the things that you've talked about today. At that meeting, I can tell you that I had what I'd call the leadership group representing the Uxbridge Cottage Hospital, of which, Minister, you would know. I've written to you on this and you have written back, thank goodness. Just to put it on the record, I saw Janet Beed, who is the president and CEO of the Markham Stouffville Hospital, which is actually the site with multi-sites. One of their multi-sites is the Uxbridge Cottage Hospital.

The issue has been around for a couple of years. In fact, it came up prior to the election last year, because the cottage hospital in Uxbridge is a new part to my riding. Prior to that was Wayne Arthurs. It's unfortunate that Wayne is not here today on this committee. He was sort of missing in action a bit. Not to be critical of Wayne; I know him very well, but it almost got ignored.

I want you to understand the context here, because the cottage hospital in Uxbridge is geographically in the Central East LHIN, but its parent hospital, its funding centre, is in the Central LHIN, so both LHINs were represented at the meeting. In fact, Hy Eliasoph from the Central LHIN—he's the CEO—and Deborah Hammons, CEO from the Central East LHIN—she's new there—were both in attendance, as were the chief of medical staff, Michael Damus, and the chair of the Uxbridge physician recruitment and retention committee, Roger Peirson. The municipality of Uxbridge was represented by Howie Herrema, who's a councillor. Mayor Bob Shepherd asked him to sit in to sort of depolarize the tone.

By the way, Minister, the tone of the meeting was extremely good, and I'm going to cover a bit of it. I hope this helps you on the ground, not at the 40,000-foot level, which you're speaking from; right on the ground, at this level.

The community wants to find a solution, but they don't want to lose their hospital and the H, that 24/7 coverage for emergency critical care. But it all fits together, and you'll see this shortly in the small bit of time that I've been given.

Tracy Evans, a young person who's the president of the Uxbridge Cottage Hospital Foundation—let's put it this way: 300-plus people were there. It was a very peaceful, very respectful meeting, with these leaders representing, basically, you, because you fund it all; let's face it. Maybe there's not enough, but that's a different question, I suppose.

I would say that in the opening remarks you made, you did mention a sum. You talked about your disappointment last year. You talked about patient-centred care. You talked about emergency rooms, which is what this is about, and the AFP issue, the alternative funding thing, and the ALC thing as well, alternative level of care. It all fits into this, and you know that as well. The aging-at-home strategy and the announcement you made last Friday of $109 million—there wasn't one nickel for this area to solve this problem. One of the emergency rooms—and I've talked to you for two years; you've been there, Minister, for too long. By the way, I have to just stop here for a minute before I get totally wound up.

Is there any truth to the rumour that you're going to run for the mayor of Toronto?

Mr. Tim Hudak: Now, hold on a second. We do have the estimates of the Ministry of Health—

Mr. John O'Toole: I'm just trying to slow down the tone here a bit. He's not paying attention. See, he's turned his back on me right now, in the meeting.

The Chair (Mr. Tim Hudak): Mr. O'Toole, you have the floor to continue with the health estimates, please.

Mr. John O'Toole: But there were a couple of things there. The international medical graduates—that was part of last night—and the CHC, the community health centres—I'm a big believer in them. There was a meeting yesterday when I believe your people were there. Foster Loucks from the Central East LHIN was there, in Brock township. They're on track for a community health centre. One in Oshawa had a celebration this week, as well as in south Oshawa. So we're not off-side on the direction at all. In fact, Janet Beed, I thought, set the tone of the meeting last night very professionally. The fact that she's legitimized in her opinions, not politicized, like perhaps George or I—any of us would be political, I suppose. She talked about health transformation. This is the right theme. This is the theme. I'm not sure all the pieces are here. George is dropping a few of them here and some money here and there, but she talked about the transformation with respect to drugs, surgical techniques and technology. The missing piece here is the e-health piece. The transformation agenda and the seamlessness of the LHINs will never work until you get that piece solved. There are a lot of people in the big debate about who owns the patient record stuff—very important legal. The doctor owns the record and the pharmaceutical companies want it to do baseline studies and things. But she gave a very thorough and comprehensive overview of what kind of leadership is required to really transform health care.

The key piece we sought in the Health Services Restructuring Commission—some of you weren't here, and I understand that. I was on the region's health and social services committee back in the 1990s. They had a thing called a capacity study—acute care study; that's what it was called. The deputy would probably remember

this. Well, you weren't there either, but you would know it in the history. It was looking at capacities in the hospitals. It started, actually, under the NDP, the capacitization study of hospitals and acute care facilities and their responsibilities.

So this transformation agenda is long-standing. We're not even halfway down the road yet. Scope-of-practice issues: You just talked about druggists doing certain things that doctors do—sign that prescription so that you can renew your Lipitor or whatever it is. It's just a waste of time. This is leadership—when you make those changes, you start tinkering with scope of practice, the professionals will line up and you'll be running for mayor of Toronto sooner than you think, because if you take them on, George, that's the deal, the scope of practice for nurses and that—

The Chair (Mr. Tim Hudak): I'm sorry to interrupt at this point—

Mr. John O'Toole: This is all going to come down to a series of questions in the last minute.

The Chair (Mr. Tim Hudak): I would ask that you use "Minister" or "Deputy Minister," depending on who you're directing comments to, as opposed to a first-name basis, and I expect the Minister then to refer to—

Mr. John O'Toole: Okay. I get a little bit emotional and enthusiastic and I hyperventilate, perhaps.

Hon. George Smitherman: You know what that leads to.

Mr. John O'Toole: Wait just a minute now, George. It's my time. We'll give you one minute to answer because in question period—he's very good on the file. I have to admit, there's hardly anybody in the room other than the staff behind him who write the answers for him, which is fine. We don't have that kind of luxury.

Also, I have to say—and these are mostly compliments—that the LHINs do talk about integration and seamlessness, right from the acuity level to the long-term care. The transformative agenda of the people who man our ambulances and emergency vehicles—that is part of the health care team now. The young doctor, Dr. Damus, was talking about the problems in emergency—and I'm going to get down to more specifics as opposed to the broad generalizations. One of the problems that I see right now is the alternative funding payment for emergency room coverage. That's pretty important. He said that in that hospital, which is mostly rural, probably a population of around 20,000 and pretty close to Southlake, which is a cardiac hospital, and pretty close to the Markham hospital site and pretty close to Lakeridge really—50 minutes, 40 minutes, somewhere in there—there is only one doctor. They have a doctor shortage—physician recruitment. They have four international medical graduates coming this summer, but they can't work alone. They need some peer mentoring of that going on, which you mentioned in your remarks too.

1650

I think if you looked site by site, you'd probably come up with some relief, and that's really what I'm appealing to you for. The alternative funding plan—there are physicians who live and practise in Uxbridge who are actually driving to Ross Memorial Hospital in Lindsay to work in emergency when they can't fully staff the emergency at the hospital in their own community. The reason why? I've asked respectfully, and they said they're not paid enough. They don't say it in that crass sort of way, that it's all about money, but it's their time that they're actually—work is selling your time. Hopefully you're an engineer or an astronaut, but work is selling your time. So they're going to Ross Memorial, where they're not alone. There are other specialists working alongside them so that if they get into a heavy case, cardiac arrest or some major deal where they maybe don't have a lot of experience, they like to have other peers around them.

So what they're saying and what they're asking for—the reason they can't recruit is because they are expected in the community to work in emergency, so there's a bit of pressure when they move in: "How come you're not doing your duty in emergency?" They're already short four physicians, and in the interview process, they say, "Would you be prepared to work in emerg.?" Many of them may have personal reasons that they don't. Now they have these four international medical grads who are planning to come some time in the summer, I think July, right after they've finished their training. There's a case there. Right today, Minister, with the power that you have at the cabinet table, you could look at that AFP. It's not a million-dollar question, George. I looked at the $109 million that you announced—

The Chair (Mr. Tim Hudak): "Minister."

Mr. John O'Toole: Minister; pardon me. Respectfully, Minister Smitherman has been here so long that it's almost like a first-name basis, but soon he'll be in Toronto.

Anyway, the $109 million—I looked at it and I checked the list. I've got the report. I checked the list, there wasn't a nickel in there, but when I checked the actual budgets, Markham-Stouffville had a deficit. Now there's this Bill 8 where hospitals are required to have a balanced budget or cut service. You don't like to admit that, but that's what it is. It's "Don't blame me. Phone the LHIN. Don't call the Minister of Health." It's sort of an arm's-length, "Out of my control; it's in the courts; I can't talk about it" kind of answer that we get in the Legislature. I'm saying today that I was disappointed in that $109 million.

Part of what you said earlier was in that, which came to the other points you were making. The ALC, alternative level of care, is part of the aging-at-home strategy. We've got to get either more long-term-care beds—and that's an argument about how many hours of care—it's all payroll; a huge issue. Aging at home is better. Supports in their community or in their home are very good. Community care already does Meals on Wheels, foot care and other things. I think that's something I would support: encouraging families to have the responsibility as long as some of the supports in the community are there. You can't possibly coordinate the logistics of—I have power of attorney for my mother-in-law. She's 90

now. She probably could have stayed in her home with some supports or some respite money, some directed funding—the son or daughter can't quit their job and take care of them at home. But they just need some supports, maybe for shopping, a bit of socialization, day programs and things like that to keep them active and keep them healthy; that's what's needed. It's better than an institution. A long-term-care solution is one of the—depending on the acuity level or the support level. In my riding—and all of us have the same issues—it's another growing issue, and I don't see a strategy there. Aging at home is part of it, but there's no money there that I see for long-term care. I guess chronic disease might be part of that.

I look at it—it's a very large ministry. Respectfully, Mrs. Witmer, when she was Minister of Health, brought a lot of compassion. She had the nursing strategy and she changed the scope of practice for nurses, nurse practitioners. When Jim Wilson was the minister, he got into trouble with the doctors a little bit but tried to change a few things in there.

You say that you're taking charge of this. These are all good ideas, but the ministry people are doing it. The people sitting behind you are actually doing this stuff. They need your leadership to make it happen. You didn't start family health teams; they were called family health networks. This is a fact. They were the same thing: collaborative health, working teams, nutritionists, pharmacists and the rest of it. I was there. I was PA to the Minister of Health for a couple of years, and it was a great ministry to work in. I was there when—this is a true story; I have a picture to prove it—in Thunder Bay, we had the first family health team. What did we call them—teams? Family health networks was our name for them. Do you know who the first one was? Dr. Neil McLeod.

Interjection: Lyn's husband?

Mr. John O'Toole: Lyn McLeod's husband was the first physician to sign on to the—it is rostering. You get so many patients; that cranks out so many monies; the doctors get that.

The issue there was how that didn't work, and they've worked on that. They have actually engaged nurse practitioners now as the front-end piece to that; the doctor's role becomes more of case management. So, actually, you're on the right track there, George. It's a plan we started. Imitation? That's fine; I have no problem with that. I think it's a good idea if you keep moving along on it. But it's the ministry people who are moving it. You're steering it; you're providing leadership. McGuinty is not providing quite enough money, because pretty well every hospital is in deficit, not just in Markham-Stouffville and Uxbridge. They're pretty well all in deficit; they are. Lou, in your hospital—I read the papers, I watch the news.

Lakeridge Health, which is the primary centre, is in a deficit. There's also a huge thing in mental health now between Lakeridge Health and Rouge Valley, moving 20 mental health beds—the most vulnerable people. Christine Elliott is doing a great job and, in fact, the Liberal members there—Joe Dickson has been very good. He knows that you made a mistake on that one. I'd go back and fix that one as well, George—

The Chair (Mr. Tim Hudak): Minister.

Mr. John O'Toole: Pardon me—Minister. I'd go back and revisit that.

I just want to get back, with the few minutes I have left, to the alternative payment plan in emergency, something you can look at. Look at each individual case; don't get the one-size-fits-all thing just based on volume. Here's the deal: It's the wrong place to get service in emergency, unless it's serious. You shouldn't get your prescriptions renewed there, or a scrape or fall or a runny nose. It's for serious challenges.

If you look at Ross Memorial Hospital, they have 35,000 patient visits. I wonder how many clinics they have for drop-ins? That would skim off a lot of the volume, which would lower their pay. That's why the people—doctors, in some cases—are driving from Uxbridge to Lindsay to work in emergency. They have more supports there as well.

I just wanted to thank the community. That's why I'm using up this time here. I hope I leave you a couple of minutes. But that is important for you to know first-hand. There was a big meeting last night. There were headlines on it:

"The June 3 meeting, to be held from 7:30 to 9 p.m. in the ... community centre ... , will feature a number of hospital figures who will 'lay out the situation ... ,' the mayor said, adding the public will have an opportunity to ask questions...."

The questions were really—this might be one question, provided you don't give me as long an answer as I do the question. Because George, he gets the clock—

Interjection.

Mr. John O'Toole: Pardon me—the Minister of Health. Once he gets the ball, I'll never get it back.

The issue there was if it came down to someone needing a cardiac intervention of some sort. The patient lives and receives service in the Central East LHIN. The funding that moves from Markham Stouffville to Uxbridge would actually go through—and I have verified this as well, Deputy. The money actually flows through Markham Stouffville through the Central LHIN, but the population-based deal of the future—you're going to have population-based funding, I hope, HBAM? Aren't you moving towards that? Hopefully. What if they have a volume issue, and the person has a cardiac arrest in Uxbridge and they want to transfer them to Southlake, and Southlake says, "Wait a minute, here. We've only got funding for 1,500 procedures" or whatever it is? How do we solve these inter-LHIN dispositions? This is a huge issue, and it always has been—the way hospitals are funded and the way they guard their funding—and I can't blame them, because there's not enough money, and we know that—even with the health tax, which is about $2.5 billion.

1700

"Why isn't it all going into health care?" is my question. Could you answer that? How would they handle that transfer between LHINs?

The Chair (Mr. Tim Hudak): This is to the minister?

Mr. John O'Toole: Yes, to the minister. It's a very technical question—

Hon. George Smitherman: Oh, not really. Firstly, I want to say thank you for your acknowledgement that anything that is good that occurs is because of the team at the Ministry of Health, and I look forward to being able to depend on that later on, when you get into saying it associated with—I'm just kidding. But there is an impressive team of people from the ministry just chomping at the bit to have an opportunity to answer some of the questions that you raise, and that will come as well.

LHINs: For a couple of reasons, the example that you pose isn't actually such a big problem for the health care system. The first reason is that LHIN boundaries right from the get-go were determined to be porous from a patient standpoint. For instance, my mother lives on the mountain in Collingwood. She lives on the edge of the South East LHIN, quite close to the North Simcoe Muskoka LHIN. She gets her care in Mississauga Halton LHIN at the Trillium hospital. She makes those drives, and that's where she gets her care. There's no problem with that.

On the issue of cardiac, firstly, if you look at the wait times, the cardiac wait times are really very good, which is telling me that there is very good access to cardiac procedures. Even on some things like angioplasty, some people are beginning to argue that there's actually too much capacity. So the cardiac capacities seem to be very, very good.

But at the heart of it, really, is just the idea that, for the purposes of serving patients, the boundaries are porous. It's not to say that we're not encouraging a health care system where you do get your care closer to home, and HBAM, as a matter of principle, helps to back that up. The aging-at-home allocation, I'd say to the member, is an example where $1.1 billion is all allocated under an HBAM model, which takes into consideration not just how many people live in a place but how healthy they are and what the existing array of services is. It is sophisticated, albeit sometimes a little bit difficult to communicate.

Mr. John O'Toole: Well, that's very good. I appreciate that very much, Minister. It's a pretty straightforward answer.

It does raise, as a debate sort of thing, the long-standing issue in GTA/905 hospitals. All of them have some stress; you'd appreciate that. The GTA/905—and you've admitted that there is some truth to how they're $200 per person short compared to other hospitals. It affects members on the other side of the table here as well that all we want is fair funding based on—I suspect we all realize that there's a limited amount of resources. That could be debated, I suppose. But how quickly are you going to make up that gap? This is very critical, because Lakeridge did some preliminary assessments on it. They've struggled; they've had a carry-over deficit. Most of them have had an operating deficit from living on cash flow, basically, for some time. They just can't seem to get out of the hole.

What are you going to do to get back to a fair starting line on that short funding in the growth-area hospitals? There was a bit of growth money in your last piece. There was a bit of the HBAM money in the last piece. What's your goal there to get equal, fair funding for every person in Ontario?

Hon. George Smitherman: There are a few things. Firstly, you've said twice now that most hospitals are in deficit etc. That's not backed up by the facts. In fact, at the last full year of consolidation, when you brought all the information on the 157, I think it was, independent health corporations, the net surplus was $292 million. You hear the story about the deficit, of course. That does come up from time to time. But the story overall with respect to hospitals when they're all brought together is that they have a substantial surplus.

Secondly, I think it's important to point out—maybe perhaps particularly to you, given your history—that every hospital in the province of Ontario has received more money each and every year, and they know years in advance what their budgetary circumstances will look like. Those are contrasts to the performance of prior governments on both of those points.

Certainly, to operate a hospital, whether it's in the highest-growth area or any other, is particularly challenging. But I just remind you that the number of people in an area is not the only thing that dictates the requirement for health services, because not all groups of population are experiencing the same health circumstances. The Chair comes from Niagara, which has a very high proportion of seniors, as an example. The north has its particular challenges. We have to be careful not to make everything on the basis of growth and ignore the principles that you've raised with respect to HBAM, which takes into consideration the health of the population.

I think that the biggest thing that contributes to addressing the growth is building. That's why, if you look at a map of the 905, which has certainly been the highest-growth area in the province of Ontario—a few other places in the province peek their noses in, but substantially it's been in the 905—go hospital by hospital by hospital. Do the map in your head. Start at the Trillium hospital and go up to Credit Valley and then into Brampton, then take a look at the circumstances that we're facing in Vaughan. Go on-site today to Richmond Hill and to Newmarket. At each and every one of these places, there's either a crane there, the crane just left or it's about to arrive. Markham is an example of that multi-hundred-million-dollar investment coming. At Lakeridge, we've had a new cancer centre open quite recently. Of course, even in Ajax, which some people would make seem like it was about to close—that's not our record, by the way; we've closed no hospital—there's a $100-million investment underway as we speak at the Ajax hospital.

I do think that the biggest thing that influences the dollars that you want to see spent in hospitals is to build

the capacity for them to deliver the services, and the 905 is having a hospital building boom. If you look just at the flow of resources to hospitals this year, you see a huge influx of new resource into Brampton, because we've recently completed and opened a new hospital.

Mr. John O'Toole: Well, I appreciate that, and, again, you're exploding with information, which is great.

The other thing too is the maturing role of the LHIN. We'll have to see if it is another level of government or just a screen, but the mandate as I see it is the rationalization of service, which becomes very controversial. You cut out pediatrics, or a program, if you will, out of one hospital because of what you said earlier—the volume issue. Because there's this great perception that every hospital does everything, really. This becomes, for each of you, and some of you who are new—if they pull a pediatrics program or a birthing program out of a hospital, they just flip out. The doctors do as well. They usually like a full-practice hospital to work in.

So, can you clarify, for instance, the capacitization and rationalization of hospitals within a LHIN?

Hon. George Smitherman: Let me say two things. Firstly, I think that you acknowledged, in the lengthy report—appropriately so; don't misunderstand me—that you gave from the meeting last night, that one person of authority after the next from health care was there and engaged with a local community. That's the best evidence. You've offered the best evidence that's available, as far as I know, for why LHINs are important.

I never pretended about this idea that LHINs were going to create some protection. When people go to vote in provincial elections, you know it and I know it: Health care is one of those things that's top of mind for them, and LHINs are not. You're not going to alter that. But we do believe fundamentally that allowing that conversation to take place locally is going to give you the best outcomes.

Rationalization? I don't use that word and I don't instigate those policies. That's the kind of word that's a hangover from your time in government, and the evidence of it is clear. In my community, where a hospital once stood, there are now condominiums. In Whitby, where a hospital once functioned, there's now a scant memory of those days.

Rationalization, though, just to use the point that you raised—of course if there's an obstetrics unit that's at risk of being moved from a hospital, there's nothing more emotional in a community like that. I've had to go into some small communities and say, "You used to do 450 births in your hospital and now it's 80." If you're giving advice to a mom about where to have a baby, the best clinical advice is to not go and have a baby at a place where they do it very infrequently. So there is always going to be a tension around trying to make sure that the program where you're going to seek the service does enough; that they do it well and safely. I know that's a tension point that is not going to go away, for sure.

1710

The Chair (Mr. Tim Hudak): We have time, Mr. O'Toole, for one quick question.

Mr. John O'Toole: Thank you. One little observation first. This goes back to my first instructive observation from the acute or capacity study that was done in the late 1990s and the Health Services Restructuring Commission's mandate to look and say, "Where are the centres of excellence? Let's build a clustering effect." This is all a continuous process, whether you're there or I'm there. I'm just saying that the rationalization—it may be a bad word, but capacitization is what they were talking about in 1994: How much capacity for what types of service? With an aging population, Minister, I still think that the technology question is the biggest one.

The Chair (Mr. Tim Hudak): We'll have to leave it at that, Mr. O'Toole. Thank you for your time.

Interjection.

The Chair (Mr. Tim Hudak): Mr. O'Toole, your 30 minutes have expired. We move to the third party. Mme. Gélinas, the floor is yours for 30 minutes.

M^me^ France Gélinas: Thank you, Mr. Chair. I must say that it is my first time attending the Standing Committee on Estimates, and I am quite impressed by the quality and breadth of knowledge of the people who are in this room with us this afternoon, and I hope to take full advantage of all of that knowledge.

I listened attentively to Minister Smitherman telling us about the two priorities of his government: family health care for all and decreased wait times. I thought I would start by outlining the priorities for the NDP, for my party. It's basically at the core of what we do. We believe in medicare. We believe in publicly funded health care services delivered based on needs, not on the ability to pay. We believe that one of the best ways to ensure that medicare is there for generations to come is what we call the second stage of medicare; that is, to make sure that investments are there in health promotion, primary, secondary, tertiary and prevention, including chronic disease management. So my questions will follow with our line of priorities.

The first priority for us is access to primary care, so everything that has to do with primary care. In primary health care, I should say, we certainly include health promotion. I realize that we now have a Ministry of Health Promotion, so some of this won't be covered here, but we are also interested in disease prevention and chronic disease management and the investments that were made there and what kind of results we can expect; a special interest in community health centres, aboriginal health access centres and community family health teams.

Our second place of interest is in home care. As Minister Smitherman alluded to, we believe that when you ask people where they want to go as they become frailer, they want to stay home. In order for that to be possible, we have to have a robust, publicly funded, publicly delivered home-care system. This is what we believe in, and we will be looking through the estimates and the budget to make sure that those kinds of services and programs have been delivered and delivered effectively.

Another area of interest for our party is long-term care. I know that I have asked quite a few questions in the House about this, but it basically comes down to: The acuity of the people who live in long-term-care homes is such that their level of care—and I will use a case mix index—has increased dramatically, which translates to higher needs, which translates to more need for hands-on care. We're really interested in achieving what we see as a reasonable average of 3.5 hours of hands-on care. So there will be questions regarding this.

Moving on: A commitment to public health is something that is also of interest to us. Here again, I've talked a little about the number of public health units without medical officers of health or acting or temporary etc., as well as the commitment of the government in general toward public health, and, here again, seeing how the investments have really made steps forward from what we learned after SARS—the after-SARS public health in Ontario. Of course, you can't come to one of those without talking about hospitals. They are such a big part, budget-wise anyway, of what the health care system is all about. We're specifically interested in the increased cost of drugs within the hospital sector. You can expect some questions about that. We also have some great interest in the different health care professionals, and we're talking here about expansions of scope of practice as well as new health care professionals joining in.

Those are the priorities for our party, so you can expect questions. Those of you who are not with this, you can rest in peace and say "Phew," and the rest of you—well, you can start reading your notes.

So, if I'm allowed, I would start with the first question, which is not going to surprise anybody—something that is very near and dear to my heart, and this is community health centres. Certainly, when I left the movement, we were 54 community health centres, with a promise of 22 new ones; there were 10 satellites with a promise of 17 new ones. My first question is simply: Where are we at?

Hon. George Smitherman: Thank you very much. Basically, we're in the midst of doubling the number of community health centre entities. Some are full-blown, if you will; some are in hub models, as you've seen emerging; and some are satellites. We're in the midst of doubling them. So we will end up at about 100. There are 28 of those that are not yet operational, and we're working diligently on bringing them to operation at present. We would anticipate over the next year or two that all of those would be operational.

Sometimes I go on, so I'll try to stop and you can reload.

M^me^ France Gélinas: That's okay. So if we take them one part at a time, you announced a three-year plan that would see 22 new community health centres. Out of those 22, how many are operational as of now?

Hon. George Smitherman: We did investments in community health centres in waves. I don't have them all separated out in my head that way, but we'll be happy to show you exactly, from which wave of announcement, the status on each of those. I'm not sure if we have that at hand, but we'll certainly give you a chart that will show exactly the status of each of those from the wave that they were announced.

M^me^ France Gélinas: Okay. I find it a little bit puzzling that if I look into this little book here, on page 144, we can see that under "Community health centres" the estimate for 2007-08 was $190 million and the estimate for 2008-09 is also $190 million. How do I reconcile the fact that the numbers are not all up and running? There will be more, yet there are no new resources?

Hon. George Smitherman: Actually it's because the number—the $190 million—was never spent. It's in the estimates, but because it contemplates all of them coming to life, and they didn't, the $190 million stands up as the number for the next year because we have an understanding of what the actual expenditures were. So the amount that's in the estimates provides for the coming to life of those, which are practically going to come to life in this fiscal year, and this amount will cover them all.

Very often you're in a situation where, at the beginning of the year, you say, "Okay, we're going to say '$190 million for community health centres.'" But if 10 of them don't open their doors and we anticipated that they would, obviously we don't get up to that number.

M^me^ France Gélinas: I understand that, but it shows in the interim—2007-08—that they spent $188 million. It now goes to $190 million, which is only a $2-million difference, when you just said that there were 29 community health centres that are not up to par. Two million dollars and 29 community health centres doesn't quite—

Hon. George Smitherman: Firstly, I said 28, and I did say, also, over the next year or two. So I don't think that we'd be anticipating that all of them would be functional in this fiscal year. I'm not sure if the deputy has any—I'm not looking at the—

Mr. Ron Sapsford: What's the page number?

M^me^ France Gélinas: Page 114.

Mr. Ron Sapsford: Page 114. Thank you.

M^me^ France Gélinas: Sorry.

1720

The Chair (Mr. Tim Hudak): The 2008-09 results-based plan briefing book?

M^me^ France Gélinas: Yes.

The Chair (Mr. Tim Hudak): The member's referring to page 114?

M^me^ France Gélinas: Yes, I am.

Mr. Ron Sapsford: It's a flat line. It's the same number year over year. There was a slight underspending for the interim actuals, so the increase for the year is the same. There is no additional increase; rather, we'll implement additional CHCs, as the minister has indicated, within this fiscal target.

M^me^ France Gélinas: Is this the same thing as saying that there's not going to be new money to fund the new CHCs?

Mr. Ron Sapsford: Correct. This number is flatlined for the year, so there has not been an additional allocation.

Hon. George Smitherman: I understand your point. I don't know the full answer, but the actual expenditure

could be representing one-time expenditures in the 2007-08 fiscal year. I understand exactly what you're saying; that it would seem that the budgetary difference between this year's estimate and last year's actual doesn't allow for new CHCs to come to life.

M^me^ France Gélinas: You've got it.

Hon. George Smitherman: It could be that there's a one-time expenditure or some other explanation. We'll seek to get you a more thorough answer on that as we move forward over the next few days.

M^me^ France Gélinas: This is a big book and I'm not that good at looking through it, but I did my best. Can you tell me what some of the obstacles are in terms of capital funding for the new CHCs? I know enough from the field to know that some of them need capital in order to be able to exist. What are some of those challenges?

Hon. George Smitherman: You will know that there are some community health centres that have been seeking capital resources for a while, and you'd also know that there are a certain number of them that are getting resources in any one year. But we also have a mechanism whereby leased space can accommodate the emergence of community health centres. I'm not sure, but I believe that the satellite that I attended the opening of while you were still the executive director is such an example, where the base budget of the organization is able to sustain leasehold space. So a combination of those strategies is what enables community health centres to come to life.

We might be able to give you some information about the capital expenditures that are on plan with respect to community health centres. I don't know if we have that at hand, but that's information that we could certainly dig up.

M^me^ France Gélinas: Do the capital expenditures come under the Ministry of Health estimates?

Hon. George Smitherman: Yes. The Ministry of Health, of course, has a partnership with the Ministry of Public Infrastructure Renewal on some of the biggest projects but maintains a capital budget which allows us to use a traditional method of capital funding, and community health centres fall under that.

Mr. Ron Sapsford: So we will build both at the same time, in terms of the implementation as well as the capital.

M^me^ France Gélinas: Along the same lines, again with community health centres: Certainly, we all agree that community health centres are really good at providing care to people who have barriers to access, but the Ontario Health Quality Council's last report also praised them for ensuring that all recommended interventions are provided. They were speaking specifically about coronary heart disease as well as diabetes. Given that and given the importance of chronic disease management, can you talk to us about the percentage of clients who are receiving care through community health centres?

Hon. George Smitherman: What percentage of the population in Ontario is receiving care from community health centres?

M^me^ France Gélinas: Yes.

Hon. George Smitherman: I think it's approximately 300,000, but that's from memory. We'll seek to get that back to you.

If you remember what I said before, the family health teams find much of their model in the community health centres. We believe that to address the kind of challenge that the Ontario Health Quality Council lays down, our obligation is to try to move all primary health care environments to a greater degree of comprehensiveness, comprehensiveness being the opportunity to support people well, especially those with chronic disease.

So between community health centres, family health teams, nurse practitioner-led clinics and physicians—who are, for example, piloting shared care with other allied professionals—we're trying to evolve the whole field of what I call "family health care" to a more comprehensive model.

We believe that community health centres play a particularly powerful role in certain communities where the underlying challenges in those communities are intense, but we see them more as a resource to be deployed in those particular underlying circumstances and the values of comprehensive care being expanded across the platform of family health care environments.

M^me^ France Gélinas: When you say "comprehensive care," do you have in mind interdisciplinary care?

Hon. George Smitherman: Yes.

M^me^ France Gélinas: You do.

Hon. George Smitherman: Yes. The reality is that, because family health teams are dealing with hundreds of thousands more—I can't remember the numbers; I think it's 1.3 million or 1.6 million people who are receiving their care from family health team environments—we've obviously made pretty good strides at expanding for Ontarians access to comprehensive care. I know that you talked about the second stage of medicare and the ideal that Tommy Douglas spoke to. I'm pretty sure that in the last four years we've made the biggest strides in that regard in the history of Ontario.

M^me^ France Gélinas: We'll be checking that out.

My second line of questioning is about AHACs, aboriginal health access centres. I don't know if you remember, but at the end of April I asked you in the House if you could look at funding for AHACs, and you responded by saying, "I will take a good hard look at the situation raised by the association of community health centres ... and I will endeavour to get back to the member and see if there are adjustments that are necessary."

I understand the AHWS strategy and I understand your ministry is but one part, but did you have a chance to look at the funding? Certainly the salaries for nurses, dietitians, social workers etc. in AHACs compare to other primary health care models.

Hon. George Smitherman: I'm not certain if that review is completed, but I did have a chance at the recent annual meeting related to all the participants in the AHWS strategy—our ministry had put forward an increase, in-year growth, for that AHWS strategy budget, but we can't obligate them to flow the money to those

elements of the AHWS strategy which are part and parcel of Ministry of Health programming. So we've identified the issue and we're working at it, but I'm not sure that it's entirely resolved.

M^me^ France Gélinas: Did I understand well that you make resources available, but we don't—say that again. We don't know where they're going?

Hon. George Smitherman: I'm sorry, yes. The AHACs are funded through the AHWS strategy, and the government of Ontario has a lead ministry for AHWS—that's community and social services—and several government ministries make a contribution to the AHWS funding. The Ministry of Health offered inflation protection. I can't remember the number, but we offered some inflation protection for our AHWS investment for this year, but we can't obligate the strategy to spend that money on those Ministry of Health-type programs. So the AHACs have suffered somewhat, or to the extent that they have, because they have been separated out from the Ministry of Health from the standpoint of funding decisions. I've sought to try to make sure that when we make a decision about community health centres, it impacts the AHACs because obviously they're so similar. I think that through the course of these estimates we'll show you the progress that we've been able to make on that point and identify where challenges and differentials remain.

M^me^ France Gélinas: Okay. So the salaries for nurse practitioners, let's say, are not set by the ministry for the AHACs?

Hon. George Smitherman: I'm not sure on the particular issue of the nurse practitioner, but the dollars that flow to the AHACs flow through the AHWS strategy, and the Ministry of Health cannot direct those. But that question that you ask is part of those which I'll have to get back to you on.

M^me^ France Gélinas: Okay. So I'll be getting more information on it?

Hon. George Smitherman: Yes, for sure.

M^me^ France Gélinas: Okay, that sounds good.

I wanted to move to family health teams. You have announced 150 family health teams fully operational by the end of 2008. When we last counted, we counted 133. Could you let us know where we're at right now?

Hon. George Smitherman: Yes. Somebody will pull that up. Very soon after the election, we took a hard look at the 150 that had been launched. There were two or three that were really—I wouldn't call them dead, but they really didn't show very many signs of life. But we've got that number up to 137 and are particularly working vigorously with those that have not yet been fully operationalized.

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M^me^ France Gélinas: Are you confident that we will reach a target of 150 family health teams by the end of 2008?

Hon. George Smitherman: I think it's possible through this fiscal year that there may be one or two or a handful that don't materialize. But overall, I think we'll get awfully close to that. Relatively soon, we'll start to be in the position of starting to look at allocating an additional 50. In any circumstance where a few just aren't going to materialize, we would, of course, allocate additional ones alongside those 50.

M^me^ France Gélinas: Okay. We'll start with the 150. Of the 150, how many of those were community family health teams?

Hon. George Smitherman: I'm not sure. It's actually—I've got a different note here, so this is even more up to date than the materials: 142 family health teams are operational, with 1.8 million patients. We expect that when they are fully operational, they will have 2.5 million patients.

On the issue of the breakdown between those which are provider-led and community-led, we'll get that information for you. I don't have that at hand.

M^me^ France Gélinas: When you make your further announcement of 50 more, or when you decide, will there be targets for the percentage of them that should be community family health teams?

Hon. George Smitherman: I'm not sure that we've contemplated that, nor am I sure that—I don't believe, for many of the approvals which I've sought through cabinet, that that's necessary. I understand where you're coming from. We certainly want to continue to promote community-based family health teams, but I think it's very, very important as well that when we allocate these additional family health teams, we're going to do so having a better understanding of where the density of patients without family health care are. That's building from that 400,000 number that the Ontario Health Quality Council has spoken to. So we certainly want to make the investment in additional family health teams very mindful of where the people are looking for care—those 400,000 especially.

I just want to be a little bit careful. I don't want to be prescriptive, to say, "In this community it must be a community one," and, "In this one we'll accept a provider one." We have to be a little bit careful not to be so prescriptive that we don't get any take-up in the communities where we really need to see action.

The second thing that we have to be mindful of—because, as you can see, some of them do take quite a while to come to life—is that sometimes evolving an existing model of primary care where there's already a group that is formed—it sometimes is a little bit easier to add to that critical mass than to build from a standing start. We have to be mindful of those challenges as well.

M^me^ France Gélinas: Okay. In the Results-based Plan Briefing Book—that's the right title, I was told—you can see a line for community health centres. But where can we see how much those 50 new family health teams will cost? Where is that?

Hon. George Smitherman: The deputy will help to direct us even more clearly, but I do want to be—I don't know the exact answer, but I do want to tell the honourable member that from the standpoint of the Ministry of Health's four-year perspective—I guess the estimates focus more on three. Is that right?

Mr. Ron Sapsford: It's only the next year, the budget numbers—

Hon. George Smitherman: Oh, so only the next year. Because we now have a better idea of, when you announce them, what the time lags are before you actually start spending substantial money, some of the family health team impact from a fiscal sense does happen a little bit down the path. So you can't always see, from the narrow view that the estimates offer of just a year or two, that the chickens come home to roost, or whatever that expression is, a little bit further out in other budgetary years.

Also, please keep in mind that it is not our intention to initiate the process around awarding additional family health teams until we've learned a little bit more about where the density of unattached patients is in Ontario. We have some ideas around it, but we're working harder to get a more sophisticated understanding of where the people are who are without doctors.

People talk about it a lot in the context of rural areas and remote areas, but we also know that there's a substantial density, especially of newcomer communities, in urban areas that experience some hardship there. We're trying to learn more about that so our allocation of family health teams is even more sophisticated than last time.

M^me^ France Gélinas: Mr. Sapsford, were you able to find in the estimates where I could find those numbers?

Mr. Ron Sapsford: Yes. It's in vote 1405, which would be, "Payments made for services and for care provided by physicians and practitioners." So with the actual expenditure—

M^me^ France Gélinas: Where? Sorry, I didn't get the page.

Mr. Ron Sapsford: Page 81.

The Chair (Mr. Tim Hudak): Page 81 in the estimates briefing book?

Mr. Ron Sapsford: Yes.

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

M^me^ France Gélinas: All right. Sorry. Go ahead.

Mr. Ron Sapsford: It's under "Transfer payments," the $9.6 billion.

M^me^ France Gélinas: Transfer payments—yes, I see this. This is as precise as we get?

Mr. Ron Sapsford: It's page 80. We're having trouble with page numbers, it seems.

M^me^ France Gélinas: Page 80.

Mr. Ron Sapsford: On the left side, under "Transfer payments," you see, "Payments made for services and for care provided by physicians and practitioners"—$9.625 billion. It's included in that provision.

If you go to the next line, the increment for 2007-08 of $265 million includes provisions for the expansion of the existing 150 that the minister talked about—opening them to larger service as well as a provision for the beginning of the introduction of the additional 50.

M^me^ France Gélinas: Are there other costs in those lines, or is that strictly for family health teams—the full $9.6 billion for new, existing, expanded and yet-to-arrive?

Mr. Ron Sapsford: If you look at page 81, you will see—

M^me^ France Gélinas: All of those.

Mr. Ron Sapsford: —all of those, that whole list of changes, additions and subtractions. The total is $311 million, which is the total increase for this vote, of which the largest portion is the $265 million—and that's the part that supports physician payments.

M^me^ France Gélinas: Do we have a breakdown as to how much is spent on physician services versus every other professional health care provider within the family health teams?

Mr. Ron Sapsford: The total expenditures are in these numbers, but I don't have the breakdown in the estimate as to the breakdown inside each family health team as to what the physician versus other providers would be.

M^me^ France Gélinas: I wouldn't need a breakdown within each one. I'm not interested in specific ones; I'm more interested in the global picture: Within family health teams, is 50% of the budget for physicians and 50% for allied health etc.? But if you could break it down even more, where I would see—

Mr. Ron Sapsford: I can endeavour to do that.

Hon. George Smitherman: I may not be right, but we'll try to zone in on it. Because we tend to aggregate those costs elsewhere, I'm not sure that the physician costs are actually reflected in that line. We will get you some clarification on that.

M^me^ France Gélinas: I was under that impression. So just to make my question clear—

Mr. Ron Sapsford: Some representation proportion between physician versus non-physician within—

M^me^ France Gélinas: But even if you could break it down some more, like, how much is spent on nurse practitioners, on nursing, on mental health services etc., would be interesting. I'm also interested in knowing: Is there any health promotion in community development investment made in family health teams?

Hon. George Smitherman: There are health promoters and there are some who are working in community development, akin to what we've seen in community health centres. What we will be able to show you, I think, is, of the allied health professionals who have been hired, how many are in each grouping. Or, we probably could give you data also on where physicians have been approved for hiring, where they rank.

You'll see some health promoters, I'm sure, doing some community development work, but it's not a very strong bias in the hiring profile so far. They've tended to be more focused on clinical service-providing allied health professionals. But you'll see a glimmer of it, I think. We'll try and get you some data on that.

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M^me^ France Gélinas: Okay. Are you looking at making sure that you build equity within the different primary health care models—equity in the form of salaries and benefits—so that one model doesn't compete against another? I understand that the AHACs are a little bit different.

Hon. George Smitherman: Yes. As a matter of principle, we do our very best in that. We've worked really hard to try and—we've had nurse practitioners in various spots in our budget over the last three or four years, and we've worked hard to try and get all of those, because maybe one year that budget line got an increase that got passed on to the nurse practitioner and maybe a nurse practitioner working in another program didn't. We have worked to try and create an equitable platform around it. It's not possible—you did say "across all the platform of primary care," and I think that we've substantively focused on that as a matter of principle.

It does get a little bit more difficult where an individual like a nurse practitioner could also work in a hospital environment, because there is some freedom. There's greater latitude in those circumstances. But I'm sure the ministry could get you some analysis about how that's working.

M^me^ France Gélinas: I understand—

The Chair (Mr. Tim Hudak): Thank you. Madame Gélinas, I'm sorry; that does conclude the—I know it goes fast. That's 30 minutes' time. There will be other rotations; just not today.

Now we go back to the minister. Minister, as we discussed at the beginning, I'll perhaps give you 20 minutes of time, and I will adjourn the meeting at 6 and give you the last 10 minutes when we next resume.

Hon. George Smitherman: Sure. That sounds great, Mr. Chair.

I want to thank everybody. It's fun to be back and to be engaged in discussion about this substantial budget and all the opportunity that's embedded within it to do good for the people of Ontario. I thought what I could perhaps do is, I took quite extensive notes through member O'Toole's presentation, and I'll try and offer some information in relation to those points that you raised.

One thing that I noted from your discussion at Uxbridge: Firstly, I do think it's important to say that we're very conscious that there has been a lot of angst in the community with respect to the future of Uxbridge. But I do want to acknowledge that for all the stories that have been written, in substantial measure because of very, very heartfelt engagement on the part of our HealthForceOntario team, which is led by Dr. Joshua Tepper, our assistant deputy minister, no hospital emergency room in the province of Ontario has lost a shift in almost two years. It's not to say that two years ago we were happy with the circumstance that occurred at that time in Leamington. But we really have brought it to a level in the ministry where, even when hospitals have decided that all is lost and they're going to put out a notice to their community to say, "Service is going to be diminishing on this weekend," or something, we have rolled up our sleeves and fought vigorously to find the resources that are required. Dr. Tepper himself is a rather unique public servant because he's not just running a big branch of the ministry; he also pulls quite a few shifts in hospital emergency rooms. I think that he fills that—in a certain sense, today we had a chance in the Legislature to talk about the remarkable life of Dr. Sheela Basrur. The ministry really does have a lot of people who are pulling like that.

IMGs are a big answer to the challenges that we've experienced with physician shortages in Ontario. This Friday we're going to have a very exciting celebration, as the first crop from the expansion of international medical graduate residency programs, which we did in 2004, are being minted. Probably some of those whom I'll meet on Friday are amongst the ones that you mentioned who are coming to the Uxbridge community. That's because we've more than doubled the number of residency positions that we have for international medical graduates. There are more barriers. My parliamentary assistant, Laurel Broten, has been working on this as her preoccupation since the election. You'll soon see a report that she has authored that will inspire our government to take even further steps on the IMG front.

Community health centres: Mr. O'Toole, the member, spoke about those which are coming to life in his area, like in Brock. We really felt that when we came to office, community health centres—I wouldn't say they'd exactly been ignored, but the opportunity to build more of them hadn't been taken up by prior governments. Some of them are slow to come to life, in part because of the difficulty of engagement with communities; sometimes, in the case of one in Ottawa, because we had a really hard time finding the appropriate physical space; similarly, one in the riding of Scarborough–Rouge River that I'm familiar with. But overall, we really see community health centres as an important part of the fabric of health care in Ontario.

On ERs, I just want to correct the record slightly. When you look at the $109 million that we laid out last Friday for our emergency room strategy, you said that none of it was going to benefit Uxbridge, or words to that effect. But the reality is that only $30 million of the $109 million is actually being allocated to hospitals, related to their emergency rooms. Most of the resources are going out to enhance the capacity for CCACs to deliver more home care. That's going to go all across the province of Ontario, and the CCACs have other increases in their budget this year.

So I just want to say that I recognize that our starting point on the emergency rooms is to tackle those that are especially high-volume and that had the most serious challenges for patients. We focus on those 23. It's a bit of a carrot-and-stick approach. Yes, they get a little bit of additional resources. They also fall under a lot more involvement and guidance from our wait times team, which, alongside Dr. Hudson, includes Dr. Michael Schull from Sunnybrook.

On the matter of hospitals, I just want to make the point to the member for Durham that I have no doubt whatsoever that running a hospital in today's environment is one of the toughest tasks that we call upon individuals to do. It's been noted in many environments that they seem to be relatively well compensated for the

difficulty of the work that is at hand. On this matter, you said at one point that they need more money. I'll put the record of our party up against yours on this matter. Hospitals in two fiscal years—in 1995-96 and 1996-97—received actual cuts to their budget. The biggest thing that you can rely upon to call "a cut" is to say that the budget didn't grow sufficiently. Every hospital in the province of Ontario has received more money every year that our party has been the government. We continue to plan for that trend.

You can see by the chart that's on offer—I think that's on the third page—that it's like steps: in 2003-04, $10.98 billion, heading towards $14.55 billion this year. So you think about it. A stable platform of hospitals in the province of Ontario, $3.5 billion more funding now than five years ago, and that's a substantial demonstration of our understanding that hospitals are so crucial in their communities. But I don't think we should pretend that you can, on the one hand, say that you should give everybody more, and also back up a commitment to cut health care revenue by up to $3 billion.

On this point that you offered with respect to the health premium, it was not accurate when you said that not every penny of the health premium is being spent in health care. When you consider that we've also created a Ministry of Health Promotion which has its own substantial resources to try and help affect the long-term health of Ontarians, those dollars are making an extraordinarily important difference. That's why we believe in that and never thought it was a good commitment to make, to eliminate the health premium. Having the health premium in place allows us to make investments in something that you mentioned a couple of times, which is electronic health. Everybody agrees that an electronic health record offers good opportunities to enhance the quality of care for individuals in Ontario. In our budget this year, we have $224 million more than we did last year for electronic health initiatives. We committed, in the election campaign, to have a fully functional electronic health record by 2015 and the commitment of the official opposition was to do that by 2014.

Our investments are going to be designed, first and foremost, to take advantage of electronic health capacity to best support people who have underlying chronic diseases, especially diabetes. We conclude that the diabetic population, estimated at 900,000—and, we all know, growing quite substantially—really does warrant the earliest focus on additional investments related to electronic health, because the complex needs of a diabetic patient are most likely to benefit from those sorts of investments. We have exciting announcements that will be forthcoming on that point.

I want to correct the record. I know I won't be successful in disabusing the member of this to the point that he stops saying it, but the family health networks that you talk about—and you tell a story about the fantastic Dr. Neil McLeod from Thunder Bay, recently retired but much loved, I know, by his patients, many of whom I've had a chance to meet. The family health network model of the prior government was certainly about rostering and about getting doctors to work in groups, but the additional staff, this interdisciplinary team approach, was virtually limited to nurses. When we have a chance to share some of the data—we've got nurse practitioners, nurses, pharmacists, mental health workers, dietitians, a much wider array of professionals that form the team.

The family health team really has, I think, been seen—and especially by some of our neighbouring jurisdictions—as one of the biggest advances in health care in the country in a long time. It's a real credit to the Premier for having put this in our campaign platform in 2003. You said that rostering is the focus of the family health network initiative. That may be the case; the team approach and comprehensiveness are the definite underlying principles of our family health team approach. I had the chance to mention, on the hospitals, that at consolidation, their budgets at the end of the last fiscal year were $282 million in surplus.

On mental health, I just want to make a point. The member for Durham quite rightly paid attention to a matter related to Rouge Valley which there has been a lot of angst around. In the modern era—I don't know what that means. In the era of the McGuinty government being in charge of health care, the discussion that gets everybody riled up is that a service is being moved. This stands in very sharp contrast to the kind of discussions that occurred, to the member for Durham, when your party had the privilege of governing health in the province of Ontario. That was about outright cuts, cuts that put thousands of people on the streets in very short order, the loss of about 20 hospitals in the province of Ontario and the diminution, as you very well know, of hospitals like the Whitby site of Lakeridge.

It's very tough, obviously, to find the perfect alignment of resources to meet all of the needs of patients as expressed by their local communities, but our record is one of having provided substantial investment all across the platform of health care, and in mental health especially. To the member for Durham, when we think about investments in mental health, we actually get to think about and talk about investments. What I came to realize, as a Minister of Health who arrived in 2003-04, is that for 12 years—dating back over difficult economic times for part of it, and explanations around all of it for sure—under the two other parties in the Legislature of Ontario, community-based mental health services didn't get a penny—not even a penny—for the costs associated with keeping the lights on in all of that.

I've really been excited to see the response of community-based mental health and addiction service organizations. They're still grappling with serious challenges in meeting the needs of Ontarians with mental health issues, that much is for sure, and we all have to agree on that, but they also have an enthusiasm because they've been given some of the resources to reach out and help people. We have additional resources in our budget for both mental health and addiction, which is going to allow us to make investments that really reach

out, and it has addressed some of the most pressing gaps in services which are there for people. I do think that mental health is one area that stands up very well to comparisons, especially.

Could I just ask how many—

The Chair (Mr. Tim Hudak): We are now at seven minutes till 6, so we'll break whenever you want and we'll give you the rest of the time when we come back.

Hon. George Smitherman: Okay. I'd be very happy to take the suggestion of the member for Durham and give everyone a chance for a short queue across the way.

The Chair (Mr. Tim Hudak): Thank you very much, Minister, Deputy and all the Ministry of Health and Long-Term Care staff who have joined us today. This means that the minister will have 17 minutes of time when we resume. That will be Tuesday, June 10 at 9 a.m.—it'll be 9 to 10:45 and then we'll resume the meeting between 4 and 6 p.m. Then we begin the 20-minute rotations equally among the three parties.

Folks, thanks very much. We are adjourned until Tuesday, June 10.

The committee adjourned at 1754.

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