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Tuesday 10 June 2008

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Mardi 10 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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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON ESTIMATES

COMITÉ PERMANENT DES BUDGETS DES DÉPENSES

Tuesday 10 June 2008

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The committee met at 0908 in room 151.

MINISTRY OF HEALTH AND LONG-TERM CARE

The Vice-Chair (Mr. Garfield Dunlop): Good morning, everyone. We'll reconvene the Standing Committee on Estimates. I'd like to remind the members that the committee will not meet this afternoon, and I want to put on the record why. The Chair, Mr. Hudak, requested that the meeting be cancelled for the following reason:

Standing order 60(e) states: "No estimates shall be considered in the committee while any matter, including a procedural motion, relating to the same policy field is being considered in the House." There is an opposition day motion on the Orders and Notices paper, to be debated this afternoon, which concerns issues of health policy. As this committee is continuing its review of the Ministry of Health and Long-Term Care, the Chair felt it would be appropriate to cancel the meeting out of respect for the standing orders. So that's the reason we won't be here this afternoon.

We are here to resume consideration of the estimates of the Ministry of Health and Long-Term Care. There is a total of eight hours and 18 minutes remaining. When the committee was adjourned, the minister had 17 minutes left to complete his reply to the opposition parties' statements and questions. Following the minister's comments, we will go to the official opposition and begin the 20-minute rotations.

Welcome this morning, Minister Smitherman, and all the members of the staff of the Ministry of Health and Long-Term Care. You have 17 minutes for your final comments.

Hon. George Smitherman: What I thought we could do with the time that we have, to be helpful to the committee, is give the deputy an opportunity to respond to some of those things which we will also subsequently table with the clerk—principally, I think, answers to questions posed by Ms. Gélinas.

The Vice-Chair (Mr. Garfield Dunlop): I appreciate that. Go ahead, Deputy.

Mr. Ron Sapsford: The first question I wanted to address was a question around the community health centre allocation. The question was with respect to the allocation for 2008-09, which is on page 114 of the results-based plan briefing book. The number for 2008-09 is showing at $190.6 million over an expenditure in 2007-08 of $188 million. The question was whether that was the only increase for CHCs.

The total planned expenditures for CHCs includes another portion of a vote in vote 1412, which is the ministry-managed vote. This is because, with the creation of local health integration networks, the estimates for the programs under their jurisdiction include the base funding in some increments. There are occasions where the government has provided a total allocation, but we have not yet allocated it among the programs and then transferred the money to the local health integration networks.

In this particular case, there is an additional $80.6 million in vote 1412, which is specifically for the support of new CHCs as they open over the course of fiscal 2008-09. So the total expenditure for CHCs in the estimate is $271.2 million for the year. I think that answers that particular question.

Similarly, in capital expenditures for community health centres in 2008-09, there's a provision for capital funding of $25 million to support the expansion program.

There was another question about the percentage of CHC registrants who have a chronic disease. It's clear that the total residents served by CHCs are approximately 350,000 Ontarians. We do not have specific information on the proportion of those people who have chronic disease. However, it's fair to say that as residents use CHCs chronic disease is, of course, one of the presenting issues that CHCs will deal with. So examples of the kind of programming in CHCs for chronic disease include diabetes, diabetes teams, chronic respiratory disease such as asthma, chronic obstructive pulmonary disease and so forth. So CHCs are staffed to deal with chronic diseases, although we don't have information about proportion of patients who present with those particular problems.

Moving on to family heath teams: a question related to the proportion of provider-led versus community-led FHTs. Currently, we're working with a total of 150, and of that 150, 81 of them are physician-led, 46 are mixed—in other words, there's a community and a physician relationship at the governance level—and 23 are community-led.

A breakdown of health practitioners in family health teams by type was another question. There's a wide variety of other practitioners beyond physicians in family health teams. A quick breakdown: the largest proportion

are nurse practitioners, at 32.9%; registered nurses, at 28%; registered practical nurses, RPNs, at 2.7%; dieticians, 7.9%; mental health workers, 10.2%; social workers, 7.9%; pharmacists, 5%; educators, 1.7%; and other, 4.1%. That's the breakdown of other practitioners currently budgeted for family health teams.

Hon. George Smitherman: But when the question was first posed, it also included: How much of that line is for physician compensation? It's important to note that none of that line is for physician compensation. That's all captured elsewhere in the OHIP line. When you see that family health team expenditure line, that's all for allied health professionals and the costs associated with the operation of the team.

Mr. Ron Sapsford: The other question was, is there funding for health promotion and community development initiatives in FHTs? The answer to the question is yes. The ministry receives applications and program proposals from the local family health team proponents. It's based on their assessment of the need for service in that particular community that we respond to. Many of the proposals have included proposals for health promotion and community development activities. Some examples include: periodic health examinations; cancer screening initiatives; immunization programs; addiction counselling, such as smoking and substance abuse prevention; as well as lifestyle counselling, which would include things like nutrition counselling and stress management counselling.

There's not a specific rule about it, but the minister responds to the proposals as they're submitted from the various communities.

There was another question: Is the ministry looking at equity in terms of payment across all primary health care models? The ministry has established a funding policy and benchmarking guidelines for salary and benefits for interdisciplinary health providers, which would include nurse practitioners. We try to be consistent across all primary-care-funded programs, such as family health teams, CHCs, primary care nurse practitioners and underserviced area nurse practitioners. There is an effort to try to have a consistent funding policy across all of these different forms. They've all started at different points in time, and occasionally there's a little bit of dislocation. We have made adjustments in the past to try to keep these programs on an even keel.

The question about funding received by aboriginal health centres: The total expenditure transfer at the moment is $10.7 million per year. As was said, that's transferred to the Ministry of Community and Social Services for aboriginal health access centres. In addition, there was an adjustment in supplementary funding of $2.3 million for nurse practitioner and physician salary enhancements in the past year. So this $2.3 million was in addition to the $10.7 million, making a total of $13 million in 2007-08 to support aboriginal healing and wellness centres.

In addition to that, there was an additional $1.23 million for 2008-09 for compensation increases for nurse practitioners and physicians in the aboriginal centres. Those are the total expenditures provided for aboriginal centres.

The final question about whether the ministry sets the salaries for nurse practitioners in aboriginal centres: As I've said, we set the benchmark and the guideline. We don't make the actual decisions; employers will actually do that. But in terms of the funding policy, we have a benchmark of a maximum salary of about $85,300 for full-time equivalent nurse practitioner positions across the community health system.

The Vice-Chair (Mr. Garfield Dunlop): Did you have further comments at this time, Minister?

Hon. George Smitherman: No, I thought maybe we'd use that up and then just begin allocating your time in whatever blocks are appropriate.

0920

The Vice-Chair (Mr. Garfield Dunlop): To Mrs. Witmer, of the official opposition. You have 20 minutes.

Mrs. Elizabeth Witmer: I want to take a look at hospitals. We know that hospitals in this province have been struggling to try to balance their budgets at a time when we have an aging and a growing population, and many of those people have some very complex needs. Certainly there has been a challenge. The hospital association, in fact, has suggested that the deficits are to some extent a result of the hospitals not being paid for all of the services they deliver and the volume of work they do. When you take a look at the increase in spending on hospitals—the 6.1%—when you remove the funding tied to specific purposes such as the wait times strategy, the amount of additional operating funding provided to the hospitals is actually below the rate of inflation. So you start to understand why they are struggling to meet the needs of their communities.

I want to ask you first to share with us the list of the hospitals that have not yet signed their accountability agreements.

Hon. George Smitherman: We'll be very happy to work on developing that list. That information of course is in the hands of local health integration networks, but I'm sure, as the estimates process continues down the path, we can provide that information.

I would want to tell the honourable member a few things. It's not accurate to suggest that funding for hospitals—firstly, a 6.1% increase is reflective not only of one-time funding for things like wait times, which are typically recurring so long as the hospital is able to deliver the volumes, but also includes increases like the post-construction operating plan because we've been so active as a government in building new hospitals. Those are, of course, base-allocated dollars. So of that 6.1%—as an example, you would see that a brand new hospital just transferred its patients successfully on the weekend in Peterborough, and that's a credit to the good people of Peterborough. They obviously worked very hard. They have a very substantial base budget increase this year, and that too is counted in that 6.1% figure.

But even as you strip away all of what you might call special items, certainly this year and in previous years hospitals have received greater than the cost of living or the inflation rates that are prepared by organizations like Stats Canada. In fact, if you look at the funding levels for Ontario's hospitals, in 2003-04, when our government came to office, it was just under $11 billion; in this year of 2008-09, it's projected at $14.55 billion. In most people's estimations, a three-and-a-half-billion-dollar annualized increase in these areas is very substantial money indeed. I note that the honourable member's very own party platform calls for the elimination of the health premium. Certainly most people would conclude that that would result in about a $3-billion pressure on the health care line.

I think there is a strong recognition of the challenging work that hospitals are involved in. What we've sought to do is make sure that we're investing in all of the pieces of health care, not just one. When we came to life as a government, we inherited a circumstance where many pieces of health care, particularly those at the community level, hadn't been receiving any increase; community-based mental health stands out as a very good example. From the last time that we were in session here—and someone will correct the number if I get it wrong—at the end of the fiscal year, the consolidated budgets of the hospitals in the province of Ontario showed a nearly $300-million surplus. While there is always an opportunity to talk about a hospital in the context of deficit, I would remind the honourable member that at the end of the year, hospitals had cumulative surpluses of nearly $300 million.

One other point which is very important: Because we now have a process which requires hospital boards and CEOs to sign on for the resources that they have allocated, all of those discussions about deficits are discussed in the first few weeks of the fiscal year of an organization. I think that that's a very good improvement, if you will, over those conversations which occur in the 11th and 12th month of a fiscal year, which had been the case over the course of the last several decades.

We recognize that the people who run our hospitals have very difficult challenges, but we also know that if hospitals are going to function, there have to be complimentary investments in those initiatives in the community without which hospitals are under even greater pressure. We've been about making investments all across the platform of health care, and we're going to continue to make sure that every hospital in the province of Ontario receives more money each year, as has been the case every year of the McGuinty government.

Mrs. Elizabeth Witmer: I thank the minister for his comments, but maybe we just need to set the record straight on a few points. I was personally thrilled to see the official opening of the Peterborough hospital. I had the pleasure, when I was Minister of Health, to make the announcement to the good folks in Peterborough. In fact, I remember we started to make the announcement out of doors, it started to pour rain, then we went inside. Our government, the Progressive Conservative government, was very pleased to have responded to the needs of that community, to see that project come to fruition, and the people of Peterborough provided with access to a state-of-the-art hospital in that community.

I'd also like to set the record straight on another point. I know the minister has continued to, I would say, mislead. Our party is not going to be taking $3 billion out of the health care system. Our party is going to make sure that all of the money that currently goes into the health tax, which, as you know, was a little bit different than what your party had committed to—they said, "No tax increases." Then, right after the election, you introduced this new health tax. We are going to make sure that all of that money actually goes to health care. We have no plans whatsoever to take any money out of the health system. So I would just put that on the record. I'd also want to say that our government committed $1.2 billion to community care programs and supports.

I'd like to go back to hospitals because, despite what the minister is saying, when I visit hospitals or people contact me, I would say to you they are experiencing a lot of difficulty in balancing their budgets. I guess I'd like to know what steps you are taking, or the LHINs are taking, to ensure that hospitals already operating in an efficient manner are funded appropriately and are not forced to cut patient care services, which we know hospitals have had to do this past year. We've seen the disappearance of some day programs, we've seen the disappearance of some staff. We can say there was no loss of staff; there was attrition. What are we doing to ensure that our hospitals that already operate efficiently are funded appropriately and are not forced to cut further patient care services in order to balance their budgets?

Hon. George Smitherman: Let me go back to this health premium issue firstly. You said—I just wrote down this quote—"Our party is going to make sure that ... all of that money actually goes to health care." But it is the policy of your party to eliminate the health premium. So we're spending just about $3 billion that the health premium provides on health care services. Your plan is to eliminate that premium and the source of revenue that it provides to the tune of nearly $3 billion. So that seems actually like a confirmation that the plan that you have as a record for your party is to eliminate a health premium which is funding health care to the tune of nearly $3 billion.

That's why I think people conclude that your party continues to be an advocate—Mr. Hudak and Mr. Tory quite recently on this point—calling for the elimination of the health premium, which we in the Ministry of Health depend upon as a very substantial source of revenue to do the very things that you would like us to do.

On this issue about efficiency, it seems like the way that you've posed those questions is to conclude that every hospital is similarly efficient, that there is in the context of $14.55 billion of expenditure no opportunity anywhere, across the broad platform of 210 physical

buildings, that hospitals can find better ways of delivering their services. I don't really think that that's a particularly viable argument. I know it's not the one that you exercised when you were the Minister of Health.

You spoke about volumes etc. All of the evidence that has been gathered—and CIHI has looked into this matter quite substantively. You know that the doctors associated with the wait times initiative have attempted to make the argument that that was leading to the cannibalization of other services. But CIHI's review of the variety of surgical procedures, even outside of the wait times area, has demonstrated actual increases in those areas.

0930

On staffing, where you talked about the spectre of layoffs or attrition, we had a chance, in discussion with your colleague who was representing you last week, to put some information into the public domain about the number of employees who are working in a variety of health care roles in the province of Ontario. In that discussion we were able to confirm that between 2003 and 2006 there has been an increase from 21,472 to 22,725 doctors practising in the province of Ontario, and by the data of the college of nurses, you can see from 2004 to 2007 an increase of just around 7,000 nurses practising in Ontario. So notwithstanding the characterizations in your question, I think it's important to reassure Ontarians that on the crucial issues of more services and more nurses and doctors, the evidence has confirmed that each of those has seen improvement during the life of our government.

Hospitals no doubt have a tough job to do. We call upon those folks to do it and they're quite well compensated to do it, but no one pretends that it's not challenging work. I really don't think that the free-for-all, whereby at the end of a fiscal year people could send you the notice and say, "Oh, by the way, we need another $300 million or $400 million or $500 million"—I don't think in your heart of hearts you believe that's a sustainable solution. I'm very proud that we've brought to the funding of hospitals a level of accountability through the accountability agreements that force people to sign on the bottom line and say, "We are going to work within the available resources," and even in that context, as I've had the case to make the point, there has been an increase in both services and staffing.

Mrs. Elizabeth Witmer: I thank the minister. I don't think he answered my question, but I'd like to go back to the health tax.

I would remind the minister that we are not going to take any money out of health care. We would ensure that the money from the health tax, however, does go directly into health care funding. I would hope that answer is now complete. There was a provincial election last fall. The voters made a decision. I would say to you, based on today, that all money collected from the health tax would be going into health care.

Some hospitals have expressed to us quietly and privately that they don't see any rhyme or reason as to how the growth funding was allocated by some—and I stress the word "some"—of the LHINs. It appears that some of the LHINs used a funding formula to determine these allocations while others simply made what appeared to be arbitrary decisions, and they didn't provide any explanation for them.

You have, I believe, a job to do. We have to make sure that there is fairness across all of the LHINs. We have to make sure there is transparency, which obviously in this case there wasn't; they couldn't provide any explanation. And we have to make sure there is accountability.

I would ask you, Minister, if you are prepared to direct all of the LHINs to use a standard formula to allocate future growth funding.

Hon. George Smitherman: First, just to your point earlier, I must confess to still being confused by your explanation with respect to the health premium. On the one hand you said that you want to make sure that it's spent on health, and it is; then, on the other hand, you said you still plan to eliminate it. In fact—

Mrs. Elizabeth Witmer: I didn't say that.

Hon. George Smitherman: I believe I have the floor, Mr. Chair.

Mrs. Elizabeth Witmer: Maybe you could just understand that we are not going to eliminate it. Okay?

Hon. George Smitherman: I'm going to provide the committee with the copies of the press release since the election from Mr. Hudak, who I think serves as the finance critic or something like that for your party, and from your leader, the unelected Mr. Tory, calling for the elimination of that premium I believe in the run-up to the budget. I think that's why a lot of us have been mystified by this constant demand for more spending when the very foundation of your plan is to eliminate resources from health care. We're having a discussion about whether hospital funding growth is enough, whereas if we look at the context of the government that you were part of, there were actual direct cuts to hospitals in 1995-96 and 1996-97 of hundreds of millions of dollars.

I think on this matter, with respect to growth funding, first is the acknowledgement that we have it. There are parts of the province that experience rates of growth that are above the provincial average. We have created capacity to allocate resources to them, particularly in recognition of that.

I must acknowledge that I have heard some criticism along the lines of those that the honourable member offered, especially from the GTA/905—I can't remember what their current name is. Tariq, from that organization, has been in touch with me by correspondence and provided me with some insight into this. Through the course of these estimates we'd be very happy to provide the honourable member with more information about HBAM, the health-based allocation model, that we spoke about somewhat last week when one of your other party representatives was in the chair, to take a good, hard look at it.

What we're trying to do is create a dynamic in the province of Ontario that allows people from closer to the action to make a greater array of decisions with respect to

the allocation of resources that are available. I do agree that on the matter of the allocation of growth funding, the information has not been available sufficiently. I will make sure, through this estimates process, that we all have an opportunity to look at it and to offer some judgment as we move forward next year with an even bigger allocation of growth funding. I'm very confident we can do so in a manner which gains the support of all parties involved. I think there is more information to bring to bear, and I look forward to a chance to get that together and present it to members of the committee in this process. I'm quite certain it can be done better, at least from a communications standpoint, but we will hold our judgment until such time as that's presented. I look forward to the opportunity to do so.

The Vice-Chair (Mr. Garfield Dunlop): You've got three minutes for questions and answers for this.

Mrs. Elizabeth Witmer: Are you saying, then, that you will direct the LHINs to use the standard formula that does demonstrate fairness, transparency and accountability?

Hon. George Smitherman: I'm saying I can't confirm at this point that that has not happened, because we're still trying to get all of the information back. I've heard the criticism, and as we get the information back, we'll put it before the committee and assess collectively whether it has met those tests that you speak about. I know it can be done better, but I have not yet concluded from my own investigation that it has gone as awry as some have suggested it has.

First we'll try and get a handle on that information. As growth funding was allocated to about five, perhaps six or even seven local health integration networks, some of them, like your home LHIN of Waterloo–Wellington, got a fairly modest amount of money overall. In other LHINs there was quite a substantial increase, for sure. I look forward to being able to present more information to the honourable member.

The Vice-Chair (Mr. Garfield Dunlop): Okay. You've got just a quick question and a quick answer.

Mrs. Elizabeth Witmer: Right. I'm going to start to focus on the Public Hospitals Act, which requires every hospital board to establish a fiscal advisory committee. I just want an update on the listing of hospitals that are in compliance with that requirement of the act, as to whether or not they've established the fiscal advisory committee. You're going to have to come back to me on that.

Hon. George Smitherman: Yes. I don't have that information at hand but, Mr. Chair, we'll endeavour to get it.

The Vice-Chair (Mr. Garfield Dunlop): Okay. That completes the official opposition. Now we'll go to the third party. You have 20 minutes, France.

M^me^ France Gélinas: Thank you. I will continue on our first priority, which is the second stage of medicare, in my line of questioning. I would like to start by thanking the deputy minister for his answers to the first series of questions that I asked last time. It's most appreciated.

Before I start into my own questions, I was just curious about one answer you gave to the member from Waterloo. You talked about an increase of 7,000 nurses practising in Ontario. The number you usually use is 8,000. Was this a mistake, or what happened?

Hon. George Smitherman: No, not at all. I've said clearly before that there is no one universal tracking measure for nurses. Most people would conclude that the most reliable data—but to anyone who's looked at this, including those that are in nursing academia, there is no one place that captures all that information. Sometimes we have information about nursing because we've flowed resources in a fiscal year for the purchase of more nursing services. But the college data might lag behind by as much as a year.

0940

What I'm offering up is from the slides that we handed out last week, which is the data from the college of nursing. I've previously been able to identify where our government's commitment for 8,000 additional nurses was fulfilled. I'm looking to offer, as best as I'm able, some confirming data which seems to underscore that there has been a substantial increase in nursing, albeit within the range of numbers that we've spoken about but not the absolute number. But on getting those numbers, if you can show me the most reliable place, I'd be happy to try to use that. This has been a real source of frustration for me, so we've used the college of nursing data, even though it does tend to lag behind a little bit.

M^me^ France Gélinas: Very good. My first question has to do with nurse practitioners. Basically, right now there is a ratio of about five nurse practitioners for a population of 100,000. I was just wondering, does your ministry have set, specific targets as to what you would like this ratio to be or is there a target at all?

Hon. George Smitherman: No. I don't know that there is a target, but Dr. Joshua Tepper, our assistant deputy minister of health human resources, with a focus through HealthForceOntario, is developing more sophisticated modelling for future numbers of health care providers that are required. But the simple answer to, "How many more nurse practitioners do we want or need?" has been, "More." We have sought to put pressure on those who teach nurse practitioners to continue to expand their capacity to do so. We've sought to find the resources to continue to grow the classes so that we can produce more nurse practitioners.

Overall, we think they're great. We see the versatility of the deployment of nurse practitioners. We know that the patient experience with nurse practitioners is very, very positive. We know that it would be beneficial to have more. That's why we've made quite substantial investments in providing for greater teaching opportunities for nurse practitioners.

M^me^ France Gélinas: When you talk about Mr. Tupple—I'm not sure if I pronounced his name properly.

Hon. George Smitherman: Tepper.

M^me^ France Gélinas: Can we expect that there will be some targets either in relation to—I know we have about 84 physicians per 100,000 population.

Hon. George Smitherman: This is Dr. Joshua Tepper. In one word of introduction, I'll just say that one thing that we've done—of course, we have to partner with the Ministry of Training, Colleges and Universities. He has the novelty, if you will, of having—he's an ADM. I think we pay all of his bills, but he also reports to the Deputy Minister of Training, Colleges and Universities because they're the production line for increasing our professionals in many ways.

M^me^ France Gélinas: Sorry about your name.

Dr. Joshua Tepper: Oh, no, that's okay. Thank you, Minister, Deputy.

There was a model developed nationally to predict the number of nurse practitioners that would be needed. We have purchased that specific model and brought it into Ontario and now we're enriching it. Nationally, the model used very simple data inputs. Because we have, actually, very good data here in Ontario, we're able to add a lot more information.

But what we're trying to do is not just use a population-to-NP ratio, because that can be very misleading. An NP working in a long-term-care home is very different from one in, say, a primary care setting. We're actually trying to say what type of team an NP can work in, what type of population they would be serving, and what the range of skills and opportunities they would bring is. Then the model can actually build quite a sophisticated set of scenarios for us.

With the increase in expansion—and again, we've gone from 75 to 150. We exceeded that number last year with an entry class of 156, and now we're climbing to 200.

So we're able to take all of that predicted supply—we actually have pretty good data on where all our existing 700-and-change nurse practitioners are—and feed all of that into the model. We'll be able to say in different types of settings—rural, urban—and different types of sectors—acute, primary care, long-term care and things like that—what the role is and what potential numbers of nurse practitioners we could see in the future.

M^me^ France Gélinas: Very good. If you could stay there, my next question is—actually, through you, and you can decide, Mr. Minister—on if there are targets for midwives. We know that 60% of people who wanted midwives were not able to secure one. Certainly we know that they also save the health care system between $800 and $1,800. Is there a target for midwives?

Hon. George Smitherman: Well, I'll let Dr. Tepper follow up with more specifics, but certainly you could almost supplement an answer about nurse practitioners with an answer about midwives. If you look at the growth in midwifery from the standpoint of funded positions—the individual compensation, which has gone up quite substantially, and the increase in the number of seats where we're training more midwives—we are seeking to try and satiate the demand that's out there on the part of patients. We fall short, of course; we haven't been able to meet that yet. But you can see from the investment stream that we're pretty dedicated to enhancing access to midwifery in the province.

Dr. Tepper may be able to provide some greater insights.

M^me^ France Gélinas: Where would I see this investment stream that you're talking about?

Hon. George Smitherman: Someone smart will pass me a note and I will tell you.

Mr. Ron Sapsford: In terms of the educational fees?

M^me^ France Gélinas: No, the minister seems to be talking about funding positions for midwifery, actually delivering here.

Dr. Joshua Tepper: The funding between the education and the clinical practice is linked, so when we increase the number of seats, as we did last year at the same time that we increased NPs, we also predict, following graduation, an increase in their practice salary. There's a really tight correlation between how many people we have in training and the number of practice positions we have.

There are three groups of providers who provide obstetrical care. I still deliver babies one night a week, so I work with midwives at Mount Sinai. So there are family doctors like myself, obstetricians and midwives.

I think you're right: In some areas you do see more demand for midwives than we have supply, but in other areas of the province we actually see midwives not even meeting their cap, and in other places we'd like to see midwives and we don't have any. So there's a range of issues and it's a range of trying to build the right supports. Midwives work in a team-based model, just like nurse practitioners, and we want to make sure that all of those providers—family doctors, obstetricians and midwives—are working in a really collaborative fashion to their appropriate and full scope of practice.

More than just an issue of numbers is an issue of the model and trying to get that model right, and again, given the difference between delivering in a northern or a smaller community versus an urban community, the types of interprofessional models you need do vary slightly, or more than slightly, as well. So again, I think midwives is another area, per the minister's comments, where we have seen significant growth both on the training side and automatically translated through into practice.

M^me^ France Gélinas: For the model you were talking about for nurse practitioners, is there work that's being done so that we know the targets of how many midwives Ontario needs?

Dr. Joshua Tepper: It's not the same piece of software. There were a number of studies done, actually, around obstetrical care and maternal-child care a couple of years ago; in fact, several studies that all converged at about the same time. They all did a number of modelling studies. Anne Biringer, for example, at Mount Sinai led one very important work through the Women's Health Council. They have done a series of models as well.

Again, the population or the birth rate varies quite substantially, depending on what part of the province you look at. Some parts of the province have a very sharply declining birth rate, and in other parts of the province there's quite a sharp increase. So it's not just a matter of overall provincial supply, but really looking at where those providers will be in terms of the model.

We do have some models; I wouldn't say they're quite as sophisticated as the one I referred to on the nurse practitioner side, but we have done some pretty good modelling. Again, there are some real issues around the difference between, say, some of the broad GTAs and then certain communities in other parts of the province, where the arrows are pointing in opposite directions for what our birthing and maternal trial needs will be.

Hon. George Smitherman: I have some of the dollar amounts with me if you'd like. It's on page 81, in the "Ontario health insurance" line.

Really, you could say that our policy works like this: They graduate, and we hire them. The anticipated growth this year is 75.

If you find the line "midwifery services," the pattern it shows is like this: In 2006-07, the actuals were $58 million; in 2008-09, the estimate is $88 million. You can really see exponential growth. It went from $58 million in 2006-07, interim actuals of $65 million in 2007-08, and a projected estimate in 2008-09 of $88 million. So we're really seeking to take advantage. That is not a human resource that, once it is available, has to wait too long, looking for opportunities. We're really taking advantage of new midwives as they are trained.

0950

M^me^ France Gélinas: Okay, thank you.

My next series of questions has to do with physicians. We still have lots of fee-for-service physicians in Ontario. According to most studies related to chronic disease management or others, they perform the worst in terms of including non-physicians on their team, as well as using electronic records and being able to provide best practice in chronic disease management etc.

What proportion of Ontario physicians are fee-for-service versus other models, whether they be blended models, salaried models etc.? What proportion are still strictly fee-for-service?

Hon. George Smitherman: I don't have those numbers top of mind, but we will get them for you. But I understand that you're in the second phase of a medicare mindset and I really think it's important to let you know about one initiative that we have undertaken. It might be something that you'll want to go and take a look at, because some of the fee-for-service physicians have expressed, through the OMA, a substantial amount of concern that our family health team model aligns additional professionals and enhances the comprehensiveness of the care that people could receive and that the fee-for-service models haven't really had very many of those advantages.

We have initiated some pilots, shared-care pilot sites—there are six of them in Ontario—where physicians have the advantage of allied health professionals working alongside them. There is one that I visited in the Jane-Finch community, where they have a very high ratio of patients in that practice who are experiencing cardiovascular challenges, diabetes etc. Similarly, I visited one just a few Saturdays ago in the Hawkesbury community, where Dr. Renée Arnold, who is the current president of the College of Family Physicians of Canada, has a shared-care pilot site where they're using allied health professionals like kinesiologists very successfully to assist people with COPD. They were telling me about some of the remarkable improvement that those patients have been able to engage.

Certainly, our focus has been substantially on evolving models of group practice, an interdisciplinary approach, but we've also started to unlock some of the opportunities to deliver more health care resources alongside fee-for-service physicians to enhance the comprehensiveness of the care that they can provide.

For me, I understand exactly where you're coming from, from a value standpoint, but I just want to say that as a Minister of Health, I have a singular obligation—I have many, but this one with respect to physicians needs to be, I think, taken very, very seriously. Ontario has thousands of physicians, and patients love them in the model of practice in which they are currently practising. We can incent them and encourage them to evolve to other forms of practice, and no physician group in the country has evolved like Ontario primary care physicians have. When we give you the numbers about the evolution to group practice etc., it has been extraordinary. But I also have an obligation to try to make sure that those doctors who are practising in that model feel rewarded and acknowledged. It's my obligation to do all that I can to keep them in practice for as long as we possibly can. If someone is a late-career doc and has been practising one way for a substantially long time, I'm not interested in sending a signal to them that the model of practice is outdated and that they should head for the hills. We need them on duty.

We're always trying to strike that balance. We love our doctors and we will support many different practice models, because patients love them too.

M^me^ France Gélinas: In that balance, do you set targets as to, "By 2009, we'd like to see that proportion working outside of fee for service," into whatever alternative model of—

Hon. George Smitherman: No. I think a greater bias has been toward creating more and more alternatives where doctors are working in group practice so that they can expand their capacities to support people after hours and so that they can sustain their practices by supporting each other after hours, rather than having doctors who are working alone and bearing the burden of being on call etc.

I think many of our standalone fee-for-service practitioners are in some ways the unspoken heroes of health care. I've seen them sustaining health care services in a lot of communities in Ontario. As long as I'm minister,

I'm not going to be involved in setting some target that sends a message that I'm trying to move Dr. X out of that mode of practice. If Dr. X is practising that way and his patients have enjoyed a relationship with him on that basis for a period of time, I'm going to be very respectful of that. I've been very clear with the Ontario Medical Association about that. But certainly through our first agreement we sought to incent a model of group and interdisciplinary practice. Those are things that we believe in, and family health teams are something that we're extraordinarily proud of.

M^me^ France Gélinas: Okay.

The Vice-Chair (Mr. Garfield Dunlop): You have three minutes for this round.

M^me^ France Gélinas: Three minutes. How can that be? Equity: How is the government ensuring that equity issues are being taken into account when setting funding levels for primary care programs? Here I talk about equity within the different LHINs, but I also talk about equity within a special population. First Nations certainly come to my mind where I come from etc.

Hon. George Smitherman: Firstly, on matters of First Nations in the context of primary care, we've got to be very clear to acknowledge that the federal government, particularly for those on-reserve populations, has the leadership responsibility for the delivery of primary care services. In terms of equity, the deputy and others may be able to offer some different approach to this answer.

What the initiatives in place have sought to do is, by designation of communities that had a lower-than-appropriate number of physicians practising in those environments, there has been this underserviced model which has sought to create some range of incentives to encourage more people to practise. We've taken that so many steps forward. On Sunday afternoon I was in Sudbury. I was also in your riding, visiting my in-laws and getting some good barbecue.

We've also spent a lot of resources building a model of distributive education for practitioners. If you want to deliver equity, you can incent that, but we also think that part of the incentive is actually training people in the very communities that are in need of service. We've taken the Northern Ontario School of Medicine approach and extended that to areas of southern Ontario which also have challenges. In the Niagara region, in Kitchener–Waterloo and in Windsor, satellite medical schools are emerging and taking students. We think this will also be very helpful in addressing access to equitable health services for the people of Ontario.

The Vice-Chair (Mr. Garfield Dunlop): I think that pretty well cleans up your time in this rotation.

M^me^ France Gélinas: When the numbers come back for that question, I'd like equity outside of northern and rural, but also equity based on income, poverty etc. Do we track this?

Hon. George Smitherman: Yes. We'll get you more information. The allocation of community health centres, as one example, is based on an understanding of what the underlying disadvantages are in some of those communities. We'll get you a more fulsome answer.

M^me^ France Gélinas: Thank you.

The Vice-Chair (Mr. Garfield Dunlop): The members of the committee will have an opportunity now to have the governing party and the official opposition for 20 minutes each, and that will take us to the end of the session this morning, just in time for five minutes before question period begins. Mr. Rinaldi.

Mr. Lou Rinaldi: Mr. Craitor.

Mr. Kim Craitor: Good morning, Minister. I have 450 questions I'd like to ask you.

Interjections.

Mr. Kim Craitor: At least you're smiling. That's good.

Hon. George Smitherman: That's a grimace.

Mr. Kim Craitor: I do have some questions that I hear people in my riding of Niagara Falls ask me all the time. I think it's really a good opportunity for you to maybe speak on them. The one I'm asked a lot about is the Ontario drug benefit program. A couple of things in how the program works: Just to tell you, many people believe literally that the Minister of Health just arbitrarily makes a decision himself or herself on the coverage of a drug, that they just decide which one should or shouldn't be covered. Many people are not aware that there is a process involved that we follow stringently when trying to determine which drugs we're able to cover, which ones are being recommended. I just wonder if you'd take a couple of minutes, before I go through the rest of the questions, just to go through that process.

1000

Hon. George Smitherman: I'm going to take a stab at it, but I'm also going to call up Helen Stevenson, our assistant deputy minister of drug programs. As my colleague from the official opposition and a former Minister of Health would know, some days you wish as a minister that you did have the power and other days you wish you had even less.

It's a little bit of a no-win situation because there are always going to be products that Health Canada has approved that are not on provincial drug formularies. There are thousands of those products and more every single day, and it's confusing to people. They say, "Well, Health Canada approved it. What is your problem?" Helen will be able to give you more information about how that process works.

One thing our initiative Bill 102 did, which we're in the midst of implementing now, that I hope can be helpful to Ontarians, because a lot of people are mystified by this process, is that we're adding a Citizens' Council. We're actually selecting people from Ontario, average Ontarians, to offer some guidance to the program around principles etc., to kind of draw the curtains back and let people in to have a glimpse of a process that is very often made out, by the media, to be about an issue that is at the discretion of the Minister of Health, and with questions posed relating to compassion etc.

Maybe Helen could offer some insights into this.

Ms. Helen Stevenson: I just thought I would begin a little bit with the timing of those reforms. As many of you know, in April 2006 Bill 102, the Transparent Drug System for Patients Act, was tabled in the Legislature and received royal assent in June 2006, and subsequently came into force in October 2006. There have been many, many significant improvements that have been brought forward into the system, and I'll speak just specifically to the ones we've implemented to improve access to drugs.

Firstly, just to speak to the whole issue about how decisions are made, we have an expert committee called the committee to evaluate drugs. As part of the improvements in the system, one of the things we did was to expand the terms of reference for that committee.

Mostly notably, what we did was to mandate the inclusion of two patient members on the committee who are there really to represent the impact of a disease on patients. The terms themselves also include as new criteria that not only does the committee look at the clinical effectiveness, they also look at the cost-effectiveness. We look at the impact of the drug on other services in the health system and also at the impact on patients.

The committee itself does a very thorough review of all the evidence and the cost-effectiveness etc., and they provide a recommendation to the executive officer, which is the role that I fill. We often listen to the concerns of a lot of the patient groups who either write in or have meetings with us and take that into consideration as well when we're making our decisions. As part of input from the team, I take into consideration not only that analysis but also the recommendation from the committee to evaluate drugs, as well as the public interest, which is part of my role, and then ultimately make a decision.

Our decisions are very much based on evidence. We do absolutely consider cost because we are to manage within a fixed budget. I would like to acknowledge that the decisions actually are often difficult. They often involve a lot of conflicting values. But it is my mandate and the mandate of our division to really focus it on the clinical efficacy, the scientific evidence and the cost-effectiveness.

I just want to mention too: Another major improvement that we implemented was around being able to list or fund drugs in different ways. In the past we had a very fixed mechanism by which we funded drugs, and we've now been able to expand that by conditionally listing drugs, which means that we enter into agreements with manufacturers that have a lot of different components in them, such as financial terms, such as being able to craft out, for instance, a very specific population for which we will fund that drug.

We continue also, just as a point, to work very hard on the exceptional access program, which is the former section 8 program, which has absolutely changed, although there have been a lot of behind-the-scenes improvements that have been made that we recognize aren't always obvious to external people. Some of those include, for instance, a web-based system that we're working on. So we're very much going to streamline that whole process, as well as implementing a phone-based system for some very targeted drugs that we fund.

I just also want to mention too this role of executive officer, which, as I mentioned, currently I fill. It has also facilitated some major improvements as well in the sense that we're now able to enter into some very detailed negotiations with pharmaceutical manufacturers. It also means that I have the authority to make the final decisions, which has really dramatically increased the time with which we get a recommendation and are then able to start funding that drug. It has also meant that we are publishing updates to our formulary on a monthly basis.

Hon. George Smitherman: Maybe we could see if he's got a follow-up, because I'm a little bit worried that we're giving him so much stuff—no chart or anything. I don't know how absorbable all of that is. Are there follow-ups on that?

Mr. Kim Craitor: Yeah, I do. The questions and answers are really for the public to hear this, because they'll come in and they'll say, "Well, Alberta's covering it, but we're not," or "We're covering a drug, and Alberta isn't covering a drug." The public has difficulty understanding why different drugs are being covered across Canada. The average person does not understand the process that it goes through, and that's really what I was trying to get at, for the average person to understand how a drug becomes covered by the province of Ontario. Because all the provinces have their own systems in determining which drugs they're going to cover; we have ours, that it's all clinically driven, right?

Let's just go through this. For a drug company, they're the ones that will come in and, after it's approved through Health Canada, then try to show us through clinical evidence that their drug should be covered. That's how the process starts. That's how it gets to you?

Ms. Helen Stevenson: That's correct. The manufacturer would put a submission to us, and that goes to our expert committee and then through the process.

Mr. Kim Craitor: The public's perception is, because it's covered by Health Canada, then why don't we just cover it automatically?

Hon. George Smitherman: Not covered; approved.

Mr. Kim Craitor: I mean approved. Thank you.

Hon. George Smitherman: If it was covered, we'd be all set.

Mr. Kim Craitor: Yes. But that's the perception out there. So every province looks at it in a different way or a similar way and decides if they're going to recognize it and cover it in their province. You're explaining how we go about doing it here in Ontario.

Ms. Helen Stevenson: Right. I'll just make three quick points in response to that. First of all, actually since October 2006 when the bill came into force, we've funded 155; so until May 2008, 155 new brand name drugs and over 200 new generic drugs. So we have dramatically added to the number of drugs that we now fund in Ontario.

As it relates to other provinces, there are actually differences. Of the programs that we cover, the largest program is the Ontario drug benefit program, which covers seniors and people on social assistance, long-term care etc. In other provinces, they cover different groups of citizens, so there is a difference there. Some of the drugs that they fund would be targeted to the beneficiaries of their public program, which aren't necessarily the same as our public program.

There are also big differences in things like copays and deductibles etc. All of those really add to the complexity of being able to compare what BC funds compared to what we fund, because there are so many other pieces that are part of it.

Then, my third quick point is that in response to the public, for instance, we now publish on our website the recommendations from our expert committee, as well as the actual decisions and all of the rationale. I happen to have brought an annual report that we've now just published that I will hand out that is for the public to really better understand, first of all, what has been implemented since October 2006 when the act came into force, but also really in an effort to dramatically improve the transparency around the program and how we make those decisions.

Mr. Kim Craitor: I don't have the figures, but what's the cost of the program for last year?

Ms. Helen Stevenson: It's $3.5 billion.

Mr. Kim Craitor: And since we've been in government, do you have an idea roughly how much it's increased?

Ms. Helen Stevenson: I can grab my book.

1010

Hon. George Smitherman: "Hundreds of millions" is one good answer, but we'll get you an absolute number.

I should also make the point, without getting into discussion of any individual drug product, that when I first became Minister of Health—and perhaps this is an experience shared by my colleague who also served—I very often used to have the executive of a drug company who would say, "We kind of have a special on this product right now." The head office would say, "We want to drive the worldwide mandate of product X, and accordingly we have an opportunity to offer you a discount off the list price," which they would not typically acknowledge to their competitors that they were doing. There was actually really no mechanism. I didn't really have a mechanism, as Minister of Health, to send them anywhere that that kind of a conversation could ensue.

Now, since the alterations we've made as a result of Bill 102, which have embedded very, very serious responsibilities—in this case, Helen Stevenson—there's a capacity for a conversation. She mentioned before that now we can do agreements where we protect ourselves against a runaway train of utilization so that we can say specifically, "Will we really see that that drug, for this subset of the population, could be extraordinarily beneficial?" An agreement can now be structured on that basis that takes the best possible advantage of the drug product as it's available and creates some pressure on the manufacturer to watch how the volumes are unfolding etc.

They have a lot of power out there, we have to acknowledge. They have big sales forces, a lot of engagement with individuals that do prescribing and the like, so that our sophistication has emerged quite a bit.

Ms. Helen Stevenson: Can I just respond to the member about the growth? In 2003-04 it was $2.3 billion. As I mentioned, it was approximately $3.1 billion in 2007-08 and forecasted at $3.6 billion in 2008-09.

Mr. Kim Craitor: The other question I have is about the creation of the—how much time do I have, Mr. Chair?

The Vice-Chair (Mr. Garfield Dunlop): You have about seven minutes.

Mr. Kim Craitor: Thank you—the creation of the Citizens' Council, the one that will be meeting twice annually. Can you kind of just walk through that again, for the public to hear what that's involved with and what the benefits are of that creation?

Ms. Helen Stevenson: Absolutely. The Citizens' Council, as the minister mentioned, is going to comprise 25 Ontarians. We're really trying to reach out to all ages and educational backgrounds and different cultural backgrounds etc. They will be coming together two times a year, at which time we will give them a topic to be able to discuss. The intention is that this group of people would not necessarily come to a consensus at the end of the two-day meeting, but rather that they would discuss the topic; they would hear from experts, for instance, around the different issues that surround that topic and they would deliberate and discuss and provide their opinions. What we're really looking for at the end of that meeting would be a report that summarizes the opinions, that summarizes some of the issues they struggled with, and how their views may or may not have changed as a result of that discussion.

Mr. Kim Craitor: Mr. Minister, I have one other question. I've been asked this many times and I think I've asked you this, maybe just sitting side by side in the House in the evening, but I'd like to ask it formally in estimates. I'm often asked by the public, is there any mechanism where at the end of the year they could receive something from the government—not from the party; just the government—that simply says, "Thank you. We're pleased to provide you with health care services for the year" and then gives them a perception of the cost of it?

It really jumped out at me when I went through my own situation with my health care, with my illness. Maybe it's because it's hard for people not to know that you're an MPP. You don't tell them, but they find that out when you're in the hospital. I remember asking questions as I went through the process: "How much is the MRI?" "How much is a CAT scan?" "How much was my hospital stay?" "How much did it cost per day?" "How much were the radiation treatments?" I kind of got an idea, because the different providers were kind enough

to just tell me, and I'm sure I was in the $50,000-plus range, just for one person to get health care.

Sometimes, when I was listening to that, I reflected on this question that was always asked to me by the public and I thought, wouldn't it be interesting if the public at least had a bit of a perception of the cost of health care? Not that you don't want to provide it and not that it's important; it's just so that they at least have a perception, because the average person has no perception of what the cost of health care is.

It's a long-winded question—

Hon. George Smitherman: No, it's a very hard question because the answer doesn't meet up with people's common sense. As a matter of common sense, you'd think, "Okay, you have a big health care system here. At the end of the year, please send me, as an individual Ontarian, a statement of the costs associated with the services that were provided in my name." I guess—and maybe I'm putting Helen on the spot slightly here—that it's relatively more possible to do that, you'd think, as a—if I was a client looking at the Ontario drug benefit, it would probably be a little bit easier to zone in on exactly what that number is.

The reason that it gets so difficult is—we were talking about hospitals extensively a few minutes ago. We're going to spend $14.5 billion in hospitals this year, and a substantial portion of what's spent in those hospitals is spent on a global budget basis. Not all hospitals have got exactly the same costs associated with the provision of a colonoscopy, as a small example. So even though that's something that I'd spoken about long before I even had a chance to be an MPP here, when I've pressed people inside my ministry to be able to do that, the answer comes back telling me about all the reasons why it's not practical or possible to do so.

We do pieces of it. For instance, as part of our OHIP verification process—I had this once at least as an OHIP client: I received a letter from OHIP asking me to confirm that on a particular date a health care provider had delivered service X. But I don't even think that at that point it had a valuation on it.

To the best of my knowledge, no, we don't have that capability. But I think that the deputy, with his long-standing perspective, may be able to tell us better why or why not.

The Vice-Chair (Mr. Garfield Dunlop): We're down to a couple of minutes, guys.

Mr. Ron Sapsford: I think the minister has covered it, basically. In certain programs where the ministry keeps track of expenditures by individual residents of the province, it's relatively easy. But in different parts of the health care system—community services would be one area; in the home care programs, in mental health programs—we don't have the information systems in place that allow us to keep track of service by individual patient in all cases.

In hospitals, the ministry doesn't ever know individual service care. We get cumulative information. For us to actually identify one person and then add up all the services and costs across all the health care programs is simply an information system that doesn't exist. As the minister said, it's in pieces. I'm not saying that it can't be done, but in order to do it we would have to spend a fair amount of money to create that kind of a system and reporting mechanism.

Hon. George Smitherman: The emergence of the electronic health record, which creates the capacity in one place for that information to flow, is one piece, as best as I can see it, of a two-part puzzle. The second piece is the costing out of thousands and thousands of distinct events and procedures, with some variation across hospitals, because a high-volume hospital may be able to do procedure X for a price at some discount compared to a lower-volume hospital. The electronic health record is the emergence of that central place where all the information settles, but this kind of year-end statement capacity is some ways off yet.

The Vice-Chair (Mr. Garfield Dunlop): Thank you so much to the governing party. Mr. Craitor, you'll be here most of the summer if you want to get all 400 questions in. We won't be with you.

1020

Hon. George Smitherman: He'll have to have me down to his community, Mr. Chair.

The Vice-Chair (Mr. Garfield Dunlop): Right on. That's for the time at the golf course down there.

We'll wind up the session this morning with 20 minutes from the official opposition. Mrs. Witmer, you can go ahead now.

Mrs. Elizabeth Witmer: That's an interesting discussion when it comes to sharing with the public the costs that they have incurred and been reimbursed for by the government. I'm not sure, if they got all the information, if they could actually appreciate it. There's a lot there.

I'm going to continue. I was on the Public Hospitals Act, and I asked for an update on the hospitals that were in compliance and had set up a fiscal advisory committee. I guess I would also ask for a list, Minister, of the hospital boards that, if they have set up these committees, have actually received recommendations from their fiscal advisory committees. Then I would go on and ask you to provide me with a breakdown of the base funding that has been provided to each hospital by their LHIN. I would further ask for a list of the breakdown of the $30 million in growth funding, where it has gone and how much to each hospital, as well as a breakdown of where the $96.2 million in post-construction operating program funding went.

Then I want to shift my focus—

Hon. George Smitherman: Could I just make a comment?

Mrs. Elizabeth Witmer: Yes.

Hon. George Smitherman: No problem. We'll start to get that together. Just two slight caveats: On the growth funding, we already had a conversation about that. You also asked a question, which was, how many have not yet signed their HAPS allocation or their HAPS

agreement? On the one hand, you're asking to know their allocation for 2008-09, which we will happily provide, but please keep in mind that you're asking us to provide you with information that some hospitals will not have signed off on yet. I just want to make clear that as we bring that information forward, some of this is still a matter of conversation, which makes slightly more dangerous—I don't know if we can asterisk it some way, but I think it's just important to note as that information comes forward. There is a slight state of flux around some pieces of it.

Mrs. Elizabeth Witmer: I'm going to turn now to the 10-year strategic plan. Minister, in Hansard, on December 20, 2006, you stated that you were going to release that 10-year plan in the spring of 2007. Since that time, we know there has been some consultation. It says that you're continuing to develop it. However, in the budget this year the 10-year strategic plan was not mentioned. It was not released, as you had indicated, in the spring of 2007. So I ask you, what is the status of the 10-year strategic plan? As you know, it was intended to guide the work of the LHINs, of the hospitals, of the CCACs and of the other health care agencies. Really, without that 10-year strategic plan, they have been left without a clear sense of how the government intends to meet the challenges of increasing costs. We've heard about the increasing drug costs, we know about the aging population, we know we've got crowded emergency rooms, we know we've got lots of people in hospitals who should be in alternative levels of care, and we have problems with the recruiting and retaining of health professionals. But suddenly the 10-year strategic plan has disappeared—not mentioned. What's happened?

Hon. George Smitherman: It's true to say, and I have to take the responsibility that we haven't hit our marks on this. The plan will be coming out this year; the deputy will zone in on a more particular date.

Firstly, we're the first ones who have undertaken this. I think that the difficulty that we were in, to be direct with you, was that the window last year got too close to the election. I certainly didn't want the work of the ministry in any way to be drawn into—because it is so substantial, as a going-forward direction and trying to get everybody on the same page based on all of the consultations that have been done. I didn't want to have a document out there in what was basically an intensely partisan period in the run-up to the election. That's why it'll be coming forward this year.

Many, many groups have had an opportunity to work with the ministry on its emergence. The deputy might be able to give you just a little more information on when we can expect it to go live, as they say.

Mr. Ron Sapsford: Chair, we've tried in this particular document to make a serious attempt to set directions in a number of different areas. We've used quite a detailed process. It started with the development of a range of topics that would be included. I think there were up to 13 or 14 different topics originally. We had specific papers written on each of these topics, all the way from health human resources to technology, its uses and application, and then through a process of distilling that down into a working document.

One of the key questions that we face in this strategic document is to what extent do we set targets and benchmarks for the future. So the second part of it, most intensely in the last six or eight months, has been around the question of setting benchmarks and targets, how to display that and how to portray that as part of the strategic plan.

That work is finishing now. As the minister said, the government's direction will come out some time, I suspect in the next several months. But the work has been long and intense. We've done a huge amount of consultation, from groups of six or eight, in terms of special expertise, to groups of 200 and 300 that we've consulted in broad discussions about strategy and targets.

Mrs. Elizabeth Witmer: Well, I guess this plan is important, as I've indicated. Of course, there is a mandatory obligation under the Local Health System Integration Act that such a plan be produced.

I guess we were rather surprised that the website www.ourplanforhealth.ca is no longer active. We couldn't find the web page. Does that mean that you have now stopped consulting with the public and with stakeholders? Is the work that you're doing now focused on completing this plan?

Mr. Ron Sapsford: Yes. The original intent of the website was to engage in that dialogue and to receive input from the public and others. That part of the work is now substantially complete.

Mrs. Elizabeth Witmer: I guess I would also ask you: You weren't able to meet what I guess was a very ambitious plan, and to share with LHINs and others this plan last year, in the spring. Are you also going to be releasing at the same time a three-year or a five-year plan?

Mr. Ron Sapsford: Together with the—

Mrs. Elizabeth Witmer: Ten-year.

Mr. Ron Sapsford: No. The cycle of three-year planning deals specifically with local health integration network planning. The ministry uses the results of that work to assist us in policy, as well as fiscal planning, for the results-based planning process. The internal estimates, year over year, and out for the next three to four years, are based to a degree on the work that the LHINs are doing in their three-year planning cycles.

Mrs. Elizabeth Witmer: So who, then, is currently working on this overdue plan? The ministry staff, consultants? Who's involved?

Mr. Ron Sapsford: Yes, it's being led in the ministry's policy division.

Mrs. Elizabeth Witmer: Okay, and you've indicated it will be released in several months. Can you be more specific, Deputy?

Mr. Ron Sapsford: Not at this point. We have to go through final review of the plan with the government and then a plan for its orderly release, so we're right at the

point of bringing it forward to government for its consideration.

Mrs. Elizabeth Witmer: I guess this is somewhat concerning. We've talked about the increasing cost of health care. We know that currently the government is spending 46 cents of every program dollar on health care. I guess it's really important that the publics knows, and that we know, that we're getting value.

We know that in 2009-10, that's going to increase to $42.4 billion, and in 2010-11, it's going to increase to $44.7 billion. I think it is absolutely critical that we have a plan that will allow us to be accountable to the public for the expenditure, and also guide the LHINs and others in their decision-making. I hope that we will see that plan earlier as opposed to later.

1030

Hon. George Smitherman: Just on the matter, though, I wouldn't want for the honourable member to conclude that people in health care are not focused on the priorities that the government has established. To be very, very clear, since the election I have been aligning resources behind the battle to address two primary objectives on behalf of patients in the province of Ontario; that is, the continued reduction of wait times with a particular focus on hospital emergency rooms. That's under the leadership of Dr. Hudson and well supported by many other health care bright lights.

The second is family health care for all. We've made great progress, alongside our partners, in delivery of primary care, community health centres, family health teams, nurse practitioner-led clinics and doctors picking up more patients at the community level; 650,000 more people have access to family health care. We feel very confident that over the next four years, we can substantively address those 400,000 people in Ontario still looking for a doctor according to the recent work of the Ontario Health Quality Council report.

I definitely agree with your comments with respect to the necessity of the strategic plan, helping to set the vision far enough in the future that people can lift up their heads and have that vision in mind. Have no doubt that the government's priorities are well established, and that across the LHINs and the ministry, people are aligning their efforts behind those two primary objectives that we seek on behalf of patients.

Mrs. Elizabeth Witmer: Thank you very much for those comments. I would stress the fact that we need the plan sooner as opposed to later. When we take a look at our hospitals and we see that in some instances 30% of our beds are occupied by patients who would be better served elsewhere, I think it helps us all to realize that we need to be able to address this situation sooner as opposed to later. In the absence of a long-range plan, sometimes it's difficult to do more, and sometimes we simply end up reacting and solving problems of today as opposed to moving forward into the future.

I guess I would just like to ask you: When it comes to these beds that are filled, when are we going to see a comprehensive plan to deal with those patients who are currently languishing in the acute care beds? When are we going to see—

Hon. George Smitherman: I'm slightly disappointed that the honourable member hasn't had an opportunity to absorb the information from our initiatives of just a week ago last Friday, I believe it was. There are two or three things that I think are important on this issue of ALC patients.

Number one, the member has quoted a figure of 30%, and certainly on some days in certain health care organizations, those numbers are hit, but overall, the numbers across health care are almost half of that at approximately 18%. There are three initiatives, which I'll tell the honourable member form a comprehensive strategy to address alternate-level-of-care patients. Firstly, there are more than 2,000 long-term-care beds, in development—brand new beds, that is—in the province of Ontario—

Mrs. Elizabeth Witmer: How many?

Hon. George Smitherman: More than 2,000. We'll get you the exact list and numbers. Those are in Ottawa, Kingston, Tweed, Trenton, London, Niagara, Sudbury, Windsor and Thunder Bay. I might've missed one place. Yes, I did; they are in Bradford. We'll be happy to provide that list.

The second piece is aging-at-home resources, which will total $1.1 billion in new resources over four fiscal years, will begin to flow with the rollout of those programs, which will take place within two weeks.

In our announcement last week with respect to emergency rooms, we have made substantial progress in arming our home care capacity with a greater degree of flexibility to enhance the hours of care they provide to support more people in their own homes or to return to their homes from the hospital. Alongside that, on the issue of comprehensiveness, are a series of other strategies which are designed to stabilize patients where they are now. For example, the mobile teams of nurse practitioners go to long-term-care homes rather than see the residents of long-term-care homes transferred to the emergency rooms. These are all part and parcel of a comprehensive strategy to address ALC.

Mrs. Elizabeth Witmer: I was at the announcement in my home community of Kitchener–Waterloo. I'm well aware of what was contained therein. I would suggest to you that it wasn't totally comprehensive; I've had an opportunity since then to talk to some of the nurses and doctors in emergency who actually approached me and indicated that this wasn't going to deal with the total problem in a comprehensive way. I also contacted our LHINs. They weren't able to give me any information as to how many people this would deal with. We've had lots of announcements, but we don't see any real people being helped, and I guess that's the concern.

Hon. George Smitherman: Well, that's a disappointing characterization because more than 100,000 additional people in Ontario are receiving home care this year than in 2003-04. I think it is easy to hide behind words saying that that was an announceable or what have you, but there's evidence that abounds about the enhance-

ments to health care services that are out there. I'll have to do a better job of pointing some of those out to the honourable member.

Mrs. Elizabeth Witmer: Well, I'd certainly appreciate that.

The Vice-Chair (Mr. Garfield Dunlop): You're down to three and a half minutes.

Hon. George Smitherman: Grand River Hospital may have been one of those places where you were speaking to people. That hospital emergency room, in the last year or two, has seen substantial reductions in its waits, it's seen substantial reductions in patients leaving without being seen and it's seen substantial increases of being able to sign up a regiment of doctors who are prepared to work in that emergency room environment. We do know that even in the honourable member's local context, there has been some pretty substantive improvement in one of those areas where there has been tremendous need for improvement.

Mrs. Elizabeth Witmer: Yes, and we were happy to see that the government finally recognized that the emergency room doctors required an increase in their salary. That certainly has contributed to the fact that we're now able to fill some of those positions, because the remuneration wasn't the same as some of the other hospitals in the surrounding community.

I was also pleased to see there was additional funding for the CCAC. I think they do good work. They certainly have been underfunded, and there was a need for more resources and human resources as well.

Hon. George Smitherman: I believe in the year 2000, you may have been the Minister of Health when the CCAC budgets were frozen. I've been in the very fortunate position of being able to invest additional government resources in expanding home care each and every year that our government has been in office.

Mrs. Elizabeth Witmer: We appreciate that.

The Vice-Chair (Mr. Garfield Dunlop): We'll get a question and an answer, and we'll clean up for the session.

Mrs. Elizabeth Witmer: So I guess I hear you say that we'll actually be able to start to identify some numbers when it comes to the aging-at-home strategy. Right now, it has been announcements; we don't really know how many people are actually going to be helped. The LHINs aren't able to give us any numbers?

Hon. George Smitherman: Even more to the point on the ALC issue and rates of ALC, through the work of Dr. Hudson, assisted by Dr. Kevin Smith, whom you know very well, local health integration networks and local hospitals and the associated services that are necessary will be working together to establish targets with respect to ALC. They'll all be pressing forward to seek to make those improvements. We all know that good health care system performance can't occur as long as we have those high proportions of beds that are being used where people are best suited for care elsewhere. Some of those very numbers you're speaking about, alongside the comprehensive investments that are being made, will certainly be emerging through the leadership of Dr. Hudson and Dr. Kevin Smith.

Mrs. Elizabeth Witmer: Great. That's why we need a strategic plan, so that we can start to measure and make sure we're achieving our goals. Thank you.

The Vice-Chair (Mr. Garfield Dunlop): That just finishes our time this morning. I gave you the reason earlier why we wouldn't be able to meet this afternoon, so the committee will reconvene tomorrow afternoon at 4 o'clock.

I want to thank the minister and all the folks in administrative help for being here. With that, this meeting is adjourned.

The committee adjourned at 1039.

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