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Tuesday 17 June 2008

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Mardi 17 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 17 June 2008

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The committee met at 0902 in room 151.

MINISTRY OF HEALTH AND LONG-TERM CARE

The Chair (Mr. Tim Hudak): Good morning, folks, members of the committee. Welcome back to the Standing Committee on Estimates for our regular meeting of Tuesday morning, June 17. There's a total of four hours and 47 minutes remaining for the estimates of the Ministry of Health and Long-Term Care. That means this morning, this afternoon's session, and we'll have an hour and a bit on Wednesday if the Legislature is still sitting on Wednesday. There may be some discussion among members about trying to move that meeting. If that's successful, I remind members that we need a unanimous motion in the House. Otherwise, if the House meets tomorrow, we're back here at 4 o'clock on Wednesday.

Last time we met, the official opposition had finished their 20-minute cycle. We now have 20 minutes for the third party. Madame Gélinas, the floor is yours.

M^me^ France Gélinas: Good morning, everybody. My first question has to do with a program called advanced access. It has been a system proven to reduce long waits for routine appointments and it has been said that if every family doctor in Canada—that applies to Ontario as well—went to advanced access, every Canadian would have access to a family physician. Would you be able to tell us a little bit about what research the ministry has conducted on advanced access? Is the ministry interested in expanding the use of this system? Are there many primary care agencies such as CHCs or others that have adopted this system?

Hon. George Smitherman: Who's the vendor?

M^me^ France Gélinas: It's not a vendor.

Hon. George Smitherman: It's free?

M^me^ France Gélinas: It's being shared, anyway. I know quite a few community health centres that use advanced access, and they certainly teach one another.

Hon. George Smitherman: I couldn't tell you that I've ever heard—obviously I've heard of the idea that there's more capacity to have routine appointments captured through a variety of software; I've never heard of that one in particular. I must confess that, as a Minister of Health, I work as hard as I can not to address health care information technology issues with a particular product, because usually there is a particular—

M^me^ France Gélinas: Vendor.

Hon. George Smitherman: —vendor, so I try to be as agnostic about that knowledge as I possibly can. I think the deputy might have some idea, or perhaps there is someone here who could speak a little bit more about electronic health. I would place such an initiative in that context, typically.

Mr. Ron Sapsford: Chair, with your permission, I'd ask Dr. Tepper to speak briefly to this issue.

The Chair (Mr. Tim Hudak): Sure. Welcome back. I wonder if you'd introduce yourself, Dr. Tepper, for Hansard purposes.

Dr. Joshua Tepper: Sure: Joshua Tepper, ADM for health human resources. Good morning.

M^me^ France Gélinas: Good morning.

Dr. Joshua Tepper: Advanced access is actually something we're very familiar with. We've done a major literature search, and we've made the results of that available to the different types of models and groups of physicians. It's also something that the physicians themselves—through your example, through the CHCs—often undertake to engage. It is part of our constant improvement process in our primary care reform models, and it's something that we continue to look at as well, working with the OMA, which also has an interest in this model and its potentials. As you know, there are some jurisdictions in Canada that have used it more than others, and we're learning from their experience.

It's certainly something we're aware of, something we've done a lot of reading and research about and something we're working on with the OMA.

M^me^ France Gélinas: So far, have the discussions been positive? Is it something that groups would like to move towards or is it too early to tell?

Dr. Joshua Tepper: As always, there are early adopters who are very interested in trying new models, so I think there are places in Ontario that are very interested in getting on board with it. Then, there are others that may wait a little bit, and that's true of the introduction of any new piece. I do know that we have groups of physicians that are very interested, and we have a lot of information available.

As you know, right now we're in the middle of OMA negotiations, and so some of those discussions are probably inappropriate to share at this point. But it is something we'll be talking with the OMA about potentially. We do a lot of work around primary care with the OMA, so we do have ongoing discussion even outside the negotiations about innovations like advanced access.

It's something we're definitely looking into a lot. Some groups are very interested; others say they feel comfortable with what they have.

M^me^ France Gélinas: Very good. My other question is—I'm kind of picking up loose ends this morning from previous ones.

Hon. George Smitherman: No problem.

M^me^ France Gélinas: One of the first bills we passed in this session was the Fairness for Military Families Act, which basically eliminated the three-month wait period for military families coming to Ontario. Can we find out how many people have been affected since we passed this bill and how much it has cost Ontario?

Hon. George Smitherman: The deputy will know whether we're able to—

Mr. Ron Sapsford: I don't have that information here for you. We would have—oh, I just have it: 48 families.

M^me^ France Gélinas: Do we know how much this has cost Ontarians?

Mr. Ron Sapsford: No. We'd have to go back and actually look at services provided. That would be a different question.

Hon. George Smitherman: And it might have privacy considerations, given that it's such a small group.

Mr. Ron Sapsford: Yes, it's more difficult.

M^me^ France Gélinas: Certainly the Association of Ontario Health Centres has been pushing to eliminate the three-month wait period for OHIP coverage for new immigrants. Given that we've had this test case with the military families, has the government studied the issue as to how much it would cost to eliminate the three-month period?

Hon. George Smitherman: I know that we just filed a request—I'm not sure on whose behalf—with the legislative library on the cost. It's an estimate based on a formula, but I'm certain that we'd be able to make that available to the committee.

M^me^ France Gélinas: Okay, thank you. Was that you who—

0910

Hon. George Smitherman: It was a request that came from the library, so we did the research. It's in our approvals process or it has been submitted to the library, so I know some research has been done on trying to make an estimate of what the cost of eliminating it would be on an annual basis. I'm quite certain that, in short order, we would be able to make that available to you and to all members of the committee.

M^me^ France Gélinas: Very good. Thank you.

Changing topics again, I'm on to medical records. There are fees charged by physicians who close their practice for people to gain access to their medical records. Has the ministry taken any action to address some of the fees that seem to be a little bit outrageous?

Hon. George Smitherman: I can't answer your question specifically about actions that we've taken, but we do keep our eye on it. We haven't moved in a regulatory fashion. I do know from my own correspondence book that it's an issue that quite a few people find very irksome—the idea that, at the end of a period of practice of a physician, the medical record that is obviously intensely personal information, is not theirs. I could identify with the issue. I understand that people have been very concerned about it, but I don't have more information about it. The CPSO would have the opportunity—it's the same with the block fees. There are guidelines around the appropriateness of this that the CPSO regulates. We could certainly make those available.

M^me^ France Gélinas: The guidelines are just that—guidelines. They say, "$1 per page for photocopies, $1.10 if it's back and forth," something like this. The problem arises when those guidelines are not followed because they are just that—guidelines. They're not mandatory fees, and physicians basically don't always charge $1 per page; they charge $300 for your chart, no matter what it is.

Hon. George Smitherman: What we could certainly do is make an inquiry of the College of Physicians and Surgeons of Ontario, when they do hear of an instance where the guidelines have not been followed or adhered to, about whether they have in their processes any investigation around that or what have you. I must confess to not knowing enough detail about it, but we'd be very happy to get more information for the committee from the college.

M^me^ France Gélinas: Okay. I'm on to another loose end, and it has to do with the marginalized—basically, we'll call it the subpopulation. Knowing the health care costs of populations such as homeless people or unemployed people on social assistance is crucial in determining what resources should be in place upstream to reduce homelessness, reduce poverty and reduce unemployment. Does the government have any way of tracking the health care costs of some of those subgroups? Is this something they're interested in? Is this something that's being done?

Hon. George Smitherman: I think we have a relatively similar question that you asked last week about some of the kinds of populations—

M^me^ France Gélinas: First Nations.

Hon. George Smitherman: —but also about the prioritization of some of the primary care investments. So I think the ministry will be working on trying to prepare some information for you about that.

There's a lot of reliance as well upon some of the work that's done from research initiatives. In my own riding, the Wellesley Institute and St. Michael's would each be very active in the area of doing urban health research, which would help to underscore some of the costs associated with the provision of health services for the homeless. I'm not sure that we have any substantial, population-wide baseline information like that. Very often, we would be relying upon a review of the literature to inform our understanding of those things.

The deputy might talk about how the ministry is being reorganized, and where we're creating better capacity around the ability to analyze more of that information and be more strategic in the deployment of resources.

Certainly, seeking to distribute resources in an equitable fashion depends more and more on knowing more than just how many people live there. A lot of people say, "Well, there are 600,000 here and 300,000 there, so we need twice as much here as there." But your question, obviously, suggests and understands that the underlying number of homeless people—or that poverty is an influence on our health circumstance and, accordingly, on health need.

We'll work to see what information we're able to provide along those lines. I don't know whether it might be helpful for the deputy to speak just a little bit about the way the organization of the ministry is evolving to take better advantage of that kind of information.

M^me^ France Gélinas: Yes; very good.

Mr. Ron Sapsford: In terms of the direct question about relating actual health care costs to actual subpopulations, we wouldn't have that database immediately available. So, as the minister said, part of the general approach is looking at the broader research available that's done at the broad population level.

Since the inception of local health integration networks, we have been looking at reorganizing the ministry into broad functional themes, and one of them that's now represented in a division is the whole issue of policy research as well as, in another division, funding models. So, very much the future agenda at the ministry is to begin to look at broad systems issues, such as the one that you've raised here today, to begin to provide better information and better analysis about future resource application, taking into consideration population needs.

One of the themes that the government has set in the implementation of all these programs is equity. So looking at different population subgroups and applying that as we move forward with program implementation is one of the key ingredients to our future work.

I think the other point I would make is that the ministry relies to some degree on responding to that kind of issue on local health integration networks. In their planning functions, as in district health councils before them, they focus on their own local population, and as they deal with service planning in their own communities they would understand at a more intimate level the needs of their community, based on issues like poverty or special-needs populations. To a degree, the ministry would rely on that work for making future investments.

M^me^ France Gélinas: All right. Does the ministry capture or is it able to extract the intelligence or data as to the percentage of the Ministry of Health and Long-Term Care's budget that is spent on health promotion and disease prevention, as opposed to diagnostic treatment etc.? And if it does, then, is there a target percentage or number that the ministry is trying to reach? I understand we have the Ministry of Health Promotion, but I'm talking within the spending of the Ministry of Health and Long-Term Care. Is there a way to keep track, and if there is, I would certainly like to know what it is and what is included.

Mr. Ron Sapsford: We don't have a running tally of that. You would have to look at the program expenditures and then make a judgment. For instance, if you look at public health, where there is a very large dollar amount in our provision, it's then a question of how much of that you would designate as health promotion or prevention. Some would argue all of it, but some of their very specific services would be excluded.

I think the other area we would look at is the screening expenditures that are in here.

Hon. George Smitherman: Vaccinations.

M^me^ France Gélinas: Yes.

Mr. Ron Sapsford: Vaccinations and so forth.

Hon. George Smitherman: Some of it's in the eye of the beholder: Is health promotion the same as disease prevention etc.? We could all work on lists. Some people would have different views about whether you see that as proactive etc., but I don't think there is one number that we have.

Obviously, as a government, it has been a substantial enough focus that the Premier felt it was important to elevate to the level of cabinet a minister who focuses much more on the proactive or, as we explain it, the idea that the Minister of Health Promotion will stem the tide of patients to health care's door. Some things are not about cost centres, like the Smoke-Free Ontario Act, which our ministry initiated, which is obviously regulatory. It's backed up by some other investments, so it's not entirely about how much it costs.

0920

M^me^ France Gélinas: The other one is not entirely about how much it costs either. It has to do with, does the government assess the health impact of other ministries' policies? Is this something that is done?

Mr. Ron Sapsford: There are, among the ministries, policy tables for discussion. So as major policies come forward from the social policy ministries, if I can describe them that way, there is a forum for discussion across the ministries about a new policy coming forward from whichever ministry. Part of the consideration in preparing positions for cabinet consideration includes impacts on other parts of the government. Often, other ministries are given the opportunity to comment directly on new policy proposals coming forward. So there is a built-in mechanism for that consideration coming forward.

Hon. George Smitherman: So when the Minister of Education moves forward with a policy of restoring daily mandatory activity, the Minster of Health at the cabinet table says, "Rah, rah, rah!" But there's not a blanket process that would put a qualitative analysis on that which says, "We think downstream that offsets this trajectory for obesity." We're not operating at that level, but typically it's more likely offered as a supporting comment, or theoretically it could be offered to say, "That's got a health implication or a health risk." I'll stop there.

M^me^ France Gélinas: No, I was interested in what you were saying. But to say that there is kind of a screen on government policies and bills to see the impact on

health is not necessarily there, but it does happen through the discussion that takes place; is this what I'm getting out of what you just said?

Hon. George Smitherman: In every item there's an opportunity for comment, but to use the word "screen" is to suggest a level of formality. What I'm getting at is that I think in some processes, you could say, "On every item that's coming forward, there will be this question asked and answered." It's not like that, but there's an opportunity for comment on all initiatives that come forward.

M^me^ France Gélinas: Okay. I'll try to get my last one in. I understand that the ministry is providing what is called the quality improvement innovation program. It's training to help professionals working in family health teams. I was just wondering if I could find out how much the ministry is spending on that training for family health teams and collaboration.

Mr. Ron Sapsford: We'll find that out, yes.

Hon. George Smitherman: I don't think any of us knows off the top.

Mr. Ron Sapsford: This was specifically for family health teams?

M^me^ France Gélinas: That's right, but I'm also interested—will that training be available to other primary care models such as CHCs, AHACs, nurse-led clinics etc.? And how much has been identified for the training to those models?

The Chair (Mr. Tim Hudak): We'll have to end it at that. Before I go to the government members, I want to recognize some special guests from the Parliament of Ghana who have joined us this morning. They were in the Legislature yesterday. We have Ms. Gloria Insaido, Mr. Kwesi Eshun, Ms. Martha Acquah Hayford, Mr. Addow Quashie and Mr. Adams Fusheini. Thank you very much for joining us. I hope you're enjoying the morning sessions.

We'll now go to the government members, who will have 20 minutes of time.

Mr. Phil McNeely: Minister, access to quality health care in Ontario is something that all members value. I understand the importance of offering a wide variety of health care services close to home. My community of Ottawa–Orléans was recently the focus of a good-news announcement from the ministry about the creation of a family health hub. How is this announcement going to benefit my community, and how is it an example of the improvements that you're making right across the health care system?

Hon. George Smitherman: I thank the honourable member. The issue of health care in your community of Orléans has obviously been a pretty hot topic. As I've had a chance to travel around Ontario looking at health care quite a lot, Orléans is a very distinct model. The Orléans Urgent Care Centre, which has been a backbone of service in the community, doesn't have too many peers. I think in Barrie, Ontario, the ministry has found one other model of urgent care that's delivering, in a community clinic, a level of service that—it isn't the same as an emergency room, you can't say that, but a very sophisticated array of services, a breadth and comprehensiveness of urgent care services that's quite impressive, from fractures and on-site diagnostic capabilities etc. We've really seen that as an opportunity, alongside other investments, to bring under one roof a lot of capacity; not a hospital, but a community health hub which has a very comprehensive array of services and can meet the needs of a growing community.

In Orléans, what I expect will emerge is something that will bear some resemblance to what St. Joseph's Hospital has in the east end of Hamilton, which is a multi-service site that has primary health care in the form of family health teams, which we've been proud to announce and which, with good capacity in Orléans, will begin to emerge. With the urgent care centre, with some additional support from the government for nursing services and overhead costs, we'll have the opportunity to bring under the same roof a lot of services that are provided, some already there and some that we would add through the Montfort Hospital. You have an MRI there; you have some mental health programs. We want to enhance the diagnostic capabilities, take a look at satellite dialysis, all emerging under one roof in a centre that will be impressive in its size.

I think it will also be a strong economic contributor. You're going to have hundreds of jobs under one roof. That's why I think, especially for our province, which has so many suburban areas that have grown so substantially, we will be able to create a template there that I'm sure will be very adaptable in a variety of other places in Ontario.

Mr. Phil McNeely: How does home care and the services that the LHIN will be delivering or be responsible for tie in? Will that tie in with this new hub?

Hon. George Smitherman: One opportunity that's certainly there—and decisions on this will have to be taken in your local community—is that sometimes people like to use the expression "one-stop shopping." You can't promise that you're going to have everything there, but certainly our community care access centres operate more than 209 distinct offices and sites. I think it's an example of how they can be well integrated into this kind of hub model.

You can see from the announcement that we had a chance to make just a few weeks ago the palpable enthusiasm of Dr. Cushman, the CEO of the LHIN, and also Gérald Savoie of the Montfort Hospital and the board chair, Mr. Lefebvre. They were in attendance and demonstrating a lot of excitement. So we've given Montfort $100,000 to start to do the planning, and your community will be engaged in that. Over the next period of months, we expect to see a very exciting template for, as I said, something that I would anticipate would emerge in other parts of the province as well.

Mrs. Amrit Mangat: My question is about the health-based allocation model. I know this question has been asked by the opposition, but I need further information about this. As you are aware, the GTA-905 is a high-growth area. I know you have created a health-based

allocation model that you use to allocate growth funding to other hospitals.

In April, you announced $30 million in growth funding for our hospitals, and in the 2008 budget there is $120 million over the next three years to help hospitals in areas experiencing high population growth to meet anticipated demand. Can you tell me how this funding will be allocated to ensure that it is fair and equitable to all communities?

0930

Hon. George Smitherman: We did have a question about HBAM, the health-based allocation model. Actually, in a second, I'm going to ask John McKinley, who is the assistant deputy minister, to talk a little bit more about that model. But first I just wanted to put some of the principles in context. It really goes back, even a few minutes ago, to the exchange that I was having with Madame Gélinas with respect to better understanding not just how many people live in a community, but what their circumstances are and how their circumstances influence the need for health care services.

Not every population of 100,000 is alike. Some are going to have a higher density of seniors, a higher density of low-income individuals, each of which would be an influence on the appropriate level of health care services that are required. Sometimes people just say, "Well, it's a high-growth community," but when we look at the greater Toronto area, we find many high-growth communities but not all of them with the same underlying demographic. If we look to the Central Local Health Integration Network as an example, we see a much higher proportion of seniors in that LHIN than in some of the surrounding LHINs. We try to establish these principles and develop a model the health care system can understand.

John McKinley will tell you something more about the methodology and how we've been working to apply it to our funding allocations in the Ministry of Health.

The Chair (Mr. Tim Hudak): So can we get John McKinley, ADM?

Mr. John McKinley: The health system information management and investment division.

Hon. George Smitherman: What is the acronym for that, please?

Mr. John McKinley: HSIMI.

The Chair (Mr. Tim Hudak): Can we print it in Hansard?

Mr John McKinley: Thank you for the question. As Minister Smitherman said, the health-based allocation model is a new model that we think is cutting-edge in the health care industry. It really is to help manage the health care system and support resource allocation decisions, basically from the ministry to the local health integration networks, and potentially the local health integration networks could use this in their decision-making to allocate resources to individual health service providers.

The model's strength comes from its focus on individual health care needs and it's about the entire population of Ontario. It's also about where they get their services, not necessarily where they live. We associate the appropriate costs with those services and then we get a good picture about what is going on with the entire population.

Some of the highlights of the model, so that you can begin to understand how we do it: We create a profile of every last Ontarian; all 12.5 million Ontarians have a profile that is built through the information sources we have that we can identify, where individuals get their care. That's from hospitals, home care and long-term care. Then we segregate them into groups of people based on the group of services they are using. A group of cardiac patients would be grouped together so that we could begin to understand the age impact of cardiac services, for example.

We also have people in this profile who have blanks. There are lots of us in Ontario who don't use the health care system. It's important to understand where the needs are and where they're not. We also look at that. Then we use these profiles to understand the relationship between age, sex and income to an individual's use of the health care system. Through that, we can predict the future use of the health care system based on how the population will change over time.

Once we have this profile, we can assign unit costs to each of those services. Those unit costs are average costs at this point; they're not detailed costs, but it's sort of like if you take a group of services and you average them out, this is what they would end up costing.

Then we know where Ontarians went for their health services. We can add up all of those services that an individual has used, where they've used them and sum them all into those LHIN regions. We begin to understand the different profile of each of the local health integration networks based on the actual services they've provided to the people who have used services inside of their area.

We can also determine how that is a percentage of the total cost. We take the total cost and we can break it up into each LHIN area. and understand from other information sources like the population information from StatsCan that works on how to predict for the future. This is where we use the model for growth. We can sort of determine the profile that exists now, see how it'll change over time, predict that change and predict the expected costs for those services in the out years.

That's exactly how we did it with the $30-million growth funding. What this allows us to do is have a standardized way of looking at the LHINs. We can compare them in a standardized way so that it's fair, equitable and based on what services they've provided and who's actually obtaining those services from that particular LHIN.

When we made the allocation, the $30 million, we looked at the growth patterns across the entire province and we picked the top 25%. Areas had to reach that threshold of being at the top 25% before they got considered for growth. Then we distributed the $30 million against those.

Mrs. Amrit Mangat: Thank you. My next question is about international medical graduates. The minister introduced the legislation yesterday. I would like to know if you have been talking a lot about your plans to increase access to family care for all. Part of this strategy is to improve access for international medical graduates. Can you tell us about your plans to continue removing barriers for these individuals?

Hon. George Smitherman: Yes, thank you. The first thing I want to say is that I know the debate yesterday in the Legislature—the discussions at ministerial statements—was maybe not so uplifting to the spirits of Ontarians, but I really think it's important to underscore that the production supply line of doctors in our province has been remarkably enlarged. We've done that; we've taken those steps. Ontarians are beginning to reap the benefits of that.

I have many IMGs in my riding and I attend many events. I know that while there is still frustration, many, many IMGs are experiencing very good progress as residents. So I think, as a premise for this discussion about reducing further barriers, it's really crucial that Ontarians understand that as much as some people will want to say that every foreign-trained doctor is driving a taxi or delivering pizza—people are addicted to saying that. I don't know whether that will ever go away, but it really is at risk of undermining many IMGs who are working hard right now.

For example, two weeks ago we had 135 international medical graduates who are now out in independent practice. They're fully licensed. They're going to places like—I met some who are going to Barrie, Oshawa and Dunnville, communities where the need is very well established. In addition to them, there are 630 other international medical graduates who are in residency programs somewhere in the province of Ontario. That's in the pipeline right now. When we came to office we had 90 positions a year. This year, in those same spots, we have 235. So we have made a good bit of progress.

On top of that, we've dramatically expanded the size of our medical schools, with 23% expansion so far in the first-year spaces. At the Northern Ontario School of Medicine we're getting quite a little bit closer to when people will actually graduate from there. So the production line has been grown a lot and the people of Ontario have put a lot of their money into it.

But we also know that there are opportunities where international medical graduates are being forced into residency positions even though their skills mean they are practice-ready. From jurisdictions like the United States and other Canadian provinces, as an example, it's really very hard to make your way into practice.

When we were re-elected as a government, I had the good fortune of having Laurel Broten as a parliamentary assistant. I said, "I'm not going to give you 100 things to do; I'm going to ask you to do one thing. Take a good, hard look at what things we can still do further to make more progress." She's come back with a report which I recommend to people. I think it's very clear, crisp and well written. Its says that there are steps that we can take to make it easier for international medical graduates to be available to our patients.

Most of that is by regulation, which we will work on over the summer. But in addition, there is a demand to make one improvement from a legislative standpoint, and that is the bill we introduced yesterday. It is a small bill, but it's to define the public interest in law in a way that says the colleges, not just the College of Physicians and Surgeons of Ontario, but all the regulated health colleges, must be mindful of the needs of the population to have access as part of the public interest. It's just a few words, but they're very powerful words and, taken together with these other steps in the regulation, working with the College of Physicians and Surgeons of Ontario, we can do better at breaking down some of those barriers.

Do I have time for two more quick questions?

0940

The Chair (Mr. Tim Hudak): You have about three minutes left in the total time.

Hon. George Smitherman: First is that we must acknowledge honestly that some people who have been licensed as doctors in other lands will not have success here. We have to be honest about that. Now we have now created opportunities like physician assistant, where we can more appropriately transition people into those roles.

The second piece is that we must be mindful at all times of shrinking the timelines because the patients of Ontario need these practitioners. That's really what the thrust of Laurel Broten's report is about. The competition is getting more intense. Accordingly, it's important that our regulatory processes, the registration and licensing, be as swift as possible, obviously always with the safety of patients and the public top of mind. I think that's what the report, the regulations and the legislation help to fuel.

Mrs. Amrit Mangat: Do the transitional IMGs have to find employers on their own or is there any process to help them?

Hon. George Smitherman: I think that Dr. Tepper might be able to quickly offer an answer there.

The idea of the transitional licence is that sometimes we will have the opportunity in Ontario to have a very specialized doctor come and practise, but maybe they have been practising in their specialized area for so long that they cannot actually successfully complete the tests that talk about areas of health care that they will never venture into. Instead of saying, "Sorry, you're a neonatologist, which we need, but you don't know enough about geriatrics, so we're not going to give you the opportunity to practise." This is about taking advertising of the skills they have by having a licence that is defined around the area where they will be practising and with the supervision of an existing practising physician.

The question was, do we assist them in finding those opportunities? Dr. Tepper is more knowledgeable than me.

Dr. Joshua Tepper: I think one of the main ways we've been able to help create better communication is through the creation of the Access centre, which by its

name is to facilitate it. This was opened by the Minister of Health and the Minister of Citizenship and Immigration about a year and a quarter ago. We've actually now been able to assist over 10,000 visits in that short time period, 75% of which are international medical graduates, but again, people from I think over 35 countries around the world.

This is basically a one-stop shop. What's very nice is that it's co-located with MCI, citizenship and immigration. You can get some very basic information about settling in Ontario and what you need to get OHIP cards and social insurance and everything, but then for the health-specifics on how to get licensed, you just move to the other side of the floor and you get a very detailed, hand-held case management approach right through the system. The evaluations have been excellent despite these thousands of people coming through in a very short time. The feedback, the evaluations—there have been two or three now—have all been absolutely excellent.

The Chair (Mr. Tim Hudak): Ms. Mangat, thank you very much. Dr. Tepper, thank you. We will now move to the official opposition. Mrs. Witmer, you have 20 minutes.

Mrs. Elizabeth Witmer: I just want to take a look at cancer treatment. There had been a recommendation made that the province should take a look at expanding chemotherapy into community hospitals where that treatment is already available. I wondered if there's funding in the budget or any indication that that might happen as we move forward in order that we can reduce the wait times.

Hon. George Smitherman: I'll get the deputy to speak specifically to the financial element.

With Cancer Care Ontario, they have been, I think since about the time I became minister, making forward-reaching reports, which provide targets for the government to fund. We've been having good success with the expansion of the regional cancer centres on the plan that they've outlined. The radiation we've done, working with them—pretty good results for Ontarians. And the greater focus is now emerging on the expanding capacity for chemo. All I could say is that we are very adherent to the advice that Cancer Care Ontario offers. They do set them out two, three years down the road, and we're obviously working at all times to try to address their needs.

I do recall that they wanted to triple their chemo funding but double the number of patients they're seeing. You have to think that's a bit of a reach, that we're going to spend three times as much to cover two times as many people. That's a costly formula at its starting point, but generally speaking, on the targets that they've established for us, I think it could be said that over the last four or five years we've been quite successful at meeting them. But I doubt very much that their forward-reaching chemo request is fully addressed in our current estimates. The deputy has probably got some real, genuine numbers there.

Mr. Ron Sapsford: Yes. In new drug funding, as specifically related to cancer, there's a provision of about $188 million in the estimates. As the minister indicated, Cancer Care Ontario manages the hospital-based chemotherapy, and to the degree, through their regional centres, they would support expansion into community hospitals, that would be done through their regional programming and then the money associated with the cost of the drugs would be flowed by CCO to those hospitals.

Mrs. Elizabeth Witmer: No, I'm well aware of the CCO reports and asks. It's always a difficult challenge to balance it all.

I guess the other thing that has been suggested is that the province change the funding formula to make it easier for hospitals to aggressively expand their chemo services and to also, obviously, hire more oncologists to drive the program. Is this being given any consideration, or will there be flexibility that would enable that to happen at all?

Mr. Ron Sapsford: The funding of cancer drugs over the history, I suppose, of the funding, where hospitals have started this in the past, many of them have allocated portions of their existing budgets—their global budgets—specifically to chemotherapy. Then, in recent years, the ministry has supplemented those lines. So it's a double question: How much can a local hospital allocate of its existing budget, plus the additional resources that come through the CCO route?

I think the model that's been chosen to deal with cancer services on the whole is this focus on Cancer Care Ontario as providing the broad policy in clinical direction for cancer treatment in the province, and then through their nine or 10 regional centres, which now are under the operation of individual hospitals. It becomes the implementation arm and, then, to the extent that there needs to be outreach with other hospitals, that discussion goes on at the local level.

In terms of expansion and in terms of oncologists and where those resources are needed, that is a discussion that goes on between CCO and their host hospitals across the province and in terms of the planning for those cancer programs. Then, what the specialist requirement is in community hospitals becomes a discussion between the local hospital and the regional cancer centre.

That's the planning framework that goes on and, of course, those decisions are made by individual hospitals in terms of how many additional oncologists, and of what type, we need to support the program in that part of the province.

Mrs. Elizabeth Witmer: The budget also committed to fund an additional five MRIs. I guess my question would be: These five MRI machines that were committed to in the 2008 budget, where will they be and when will they be fully operational?

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Hon. George Smitherman: We'll get you the complete list because I run the risk of making an error top of mind. But I think that one is Chatham and one is at the Montfort in Ottawa. I just want to be careful about supplying the rest of them because I may have in my mind MRIs that are still being implemented but actually

were in a previous number. I must confess that when we look at the quantum of resource that's available and we look to the needs—we spoke a little bit about the Cambridge-Kitchener situation.

Mrs. Elizabeth Witmer: We did.

Hon. George Smitherman: I'm actually hoping that of the allocation that the Ministry of Finance spoke about as five, we were actually—I'm not sure. There was a bit of miscommunication between the ministries because actually we were thinking more like three or four new MRIs and the additional operating resources to expand capacity. We have capacity available in the Kitchener–Waterloo region at the off-site—I'm not sure how to best describe it, but the not-for-profit that I described before. So I'm hoping that some of that operating resource would be made available to expand capacity at that one. I don't think we've decided on five, but I do know that the budget papers spoke to five.

I could just confirm that three of the five—Chatham, as I mentioned, Montfort and St. Joe's in Hamilton.

Mrs. Elizabeth Witmer: All right. I thank you for that information. I want to go now—

Hon. George Smitherman: And I've got several members on the committee who have ideas about other local—well, I have at least one member of the committee who has an idea about another localized deployment, but I won't mention the member for Quinte West.

Mrs. Elizabeth Witmer: No doubt.

I want to go to out-of-country health coverage. That particular program wasn't mentioned in the budget. I know that last year, in January 2007, you indicated that parts of that program were going to be under review based on the advice you'd received from the Ombudsman. I just want to know the status of this review and how much money is going to be set aside this year for out-of-province coverage.

Hon. George Smitherman: After the Ombudsman's work, we asked Mary Catherine Lindberg, who is very well known to you, but for the members of the committee, in her day job she serves as—I'm not sure of her title—the director of the Council of Academic Hospitals of Ontario, CAHO. She has provided some advice to the ministry and we're working to incorporate that advice.

I must confess to being uncertain about where this is in the order-in-council process, but we're asking the chair, Linda Lamoureux—we're going to have a new chair at the Health Services Appeal and Review Board. I had a discussion with her a couple of weeks ago. I believe strongly that the out-of-country program is an exceptionally important feature of the Ontario health care system. If the health care system in itself is designed to be, as some people would use the expression, like a safety blanket, then the out-of-country program is even further down. It's designed for a circumstance, where we can't get the job done appropriately here, to still help an Ontarian.

It's a really tough thing because some people will go on the Internet and they'll find a service or a surgery or an idea that offers them hope, and you can't fund everything. Nevertheless, I really think that the out-of-country program is a feature that I'm proud of. Some people point it out as a weakness, but I've always seen it, as an Ontarian, as something that I'm proud of. But we need to make it work better, to be more understandable, to be more transparent.

The deputy could speak to some of the numbers, but I did just want to mention one particular initiative or idea. What we've tried to do is take a look at what the out-of-country program tells us about our inadequacies. One very precise example of this is that in the last little while there's been a real, substantial increase in the number of out-of-country approvals for bariatric surgery. So we're really working very vigorously right now on building up our capacity in Ontario with a good, province-wide network of access around bariatrics that, in the next two or three years, is going to emerge to be really substantial.

On youth drug treatment, we are sending hardly any—I think it has been almost none. We have enhanced our capacity in Ontario for youth drug treatment so that we're not sending the kids—there might be some who are completing treatment etc., but as a matter of course for about a year now, we have sufficiently enhanced capacity to take care of our own here. That's because we're looking harder at what the data tell us about inadequacies. So that's just as a matter of principle something that I would like all members of the committee to know.

The deputy may have uncovered some funding numbers particular to the out-of-country program.

Mr. Ron Sapsford: Chair, the estimates contain in the range of $170 million for out-of-country.

Just to add to what the minister said about the report, one of the concerns raised by the Ombudsman which led to the report was some of the process around how approvals were obtained and given by the ministry. So we've made a number of changes in the process.

First of all, we have communicated to all physicians in the province to reinforce what the process is. It is on application for out-of-country—

Mrs. Elizabeth Witmer: Prior.

Mr. Ron Sapsford: Prior—for prior approval. And the application must come from the attending physician. We have made a great deal of clarity in what kinds of requests are acceptable. We've changed the response process so that where an application is received and the information is not complete, we now contact the referring physician to understand, on a case-by-case basis, more details about what the clinical request actually is.

These are all changes from the old process, so that it's understandable, clearly communicated. The reasons for a decision not to approve a referral are given and communicated back to the physician and the patient. These are all improvements that we've made subsequent to the report the minister referred to.

Mrs. Elizabeth Witmer: So these were all recommendations made by Ms. Lindberg, based on her review?

Mr. Ron Sapsford: A combination of that report, as well as the Ombudsman's original concerns.

Mrs. Elizabeth Witmer: If we take a look at, for example, PET scans, there has been an increase, I guess, in recommendations by some physicians for patients to have access to a PET scan. And if you don't fit the basic criteria, then you have no choice but to go either to the private clinic in Mississauga or up to Quebec or across the border.

What is the ministry's position on those PET scans that are being recommended by physicians in Ontario?

Hon. George Smitherman: I think the deputy, or others, could offer some additional helpful information.

I would just like to say a couple of things with respect to PET scans. Firstly, we do have five active clinical trials. I made the point before and I think it's very important that, as Minister of Health, I be very forthright with Ontarians on this point. Sometimes something comes up and it seems like a panacea, and PET scans seem to enjoy some reputation on that basis. But they're very expensive, and the basis of knowledge about where they actually are effective is something that Ontario is leading the way on and that other jurisdictions, such as Australia, as one example, are keenly watching.

So we have advanced clinical trials in five distinct indications for which a PET scan might be appropriate, and we're working on that in Ontario. That's offering access to Ontarians through a mechanism that physicians can apply for. It's not specific to the out-of-country, but just on the issue of PET scans. We are working vigorously to ensure that any government that seeks to deploy PET scans as a standardized element of diagnostics in the province of Ontario would be able to do so in a way that has very strenuous clinical guidelines. It can't be that a PET scan is going to be the diagnostic answer to every indication. We're working very hard to know precisely where this expensive technology is most effective so that its deployment can be done in the most strategic way, because the costs associated with the provision and deployment of this technology are very high.

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Mrs. Elizabeth Witmer: There was an article by a lawyer who indicated that the province now must pay for PET scans that were obtained in hospitals in other provinces. Apparently, there was a case prior to the end of last year. I'd like to know whether or not that is true.

Hon. George Smitherman: I think that on the matter you first raised, on the out-of-country PET scans, and in this particular instance—

Mrs. Elizabeth Witmer: Yes, I'm talking about hospitals in other provinces. There was a media story that indicated that, on appeal, OHIP had been forced to pay for a PET scan that had been obtained in a hospital in another province. I just want to know if indeed that precedent has now been set.

Hon. George Smitherman: I don't have information on that.

Mr. Ron Sapsford: Chair, I'll check for the member and bring the answer. I'm not immediately aware of it. PET scans are non-insured services in Ontario.

Mrs. Elizabeth Witmer: But apparently there was an appeal.

The Chair (Mr. Tim Hudak): So the deputy will report back through the committee.

Mr. Ron Sapsford: Yes.

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

Mrs. Elizabeth Witmer: I'd also like to know how many people have been reimbursed for PET scans that they went to the United States or to another province to have administered.

Hon. George Smitherman: Sure. We'll get that information together. I assume that information is available.

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

Mrs. Elizabeth Witmer: And the last question on PET scans: Minister, when do you see the end of the clinical trials and criteria put in place so that all Ontarians could have equal access? I don't disagree as to the cost and the appropriate use. I think that goes for CAT scans, MRIs and ultrasounds—all diagnostic imaging. You'd have to make sure that the use of all of this new technology is appropriate. So my question is, when will we be reimbursing Ontarians and when will all people have equal access?

Hon. George Smitherman: I think there is equal access at present because the mechanisms—

Mrs. Elizabeth Witmer: When will the trials end?

Hon. George Smitherman: I don't know when the trials will end, but I was clear in saying to the committee—I think I did talk about this at the committee—that for the estimates that are before us, there is no additional funding for the implementation of PET scan technology beyond the existing trials.

Mrs. Elizabeth Witmer: Right. I see that. Do you have something further, Deputy?

Mr. Ron Sapsford: No. I think, in answer to previous questions, some of the trials are in fact finished. In the cases where the trials are finished and the analysis is done, then the ministry converts to a registry; which is to say that there is access for all Ontarians with the appropriate clinical criteria. So there then is no question about screening. If the patient presents with a condition, then access is given to the PET scan through the registry.

Mrs. Elizabeth Witmer: How many trials are done of the five?

The Chair (Mr. Tim Hudak): I'm sorry, Mrs. Witmer, the time has expired. If you want to answer that quickly, you can go ahead, but time has expired.

Mr. Ron Sapsford: I think two of them are now—

The Chair (Mr. Tim Hudak): Sorry, I'm going to have to cut it off. That is the full 20 minutes. We'll have another chance for rotation this afternoon.

Madame. Gélinas, you have 20 minutes.

M^me^ France Gélinas: My next question is about home care. I did get the copy of the interim contract management guidelines for community care access centres. My first question refers to point 2, which I'm sure you haven't memorized, so I'll tell you what it's about.

Hon. George Smitherman: I'm not sure I'd seen till this morning.

M^me^ France Gélinas: Oh well, no problem. Basically, point 2 in the June 2 guidelines to CCACs allowed for contracts to be extended for up to 24 months, but all decisions by CCACs to renew or extend contracts must be within the CCAC approval level of funding. I get out of this that there won't be any new funding for community care access centres for the next two years.

Hon. George Smitherman: No, no. They have approved additional funding in three different pots, I think. This just says, "You can't go and do contracts that extend beyond the allocation of resource that's made available. And, by the way, please don't spend every dollar that we have on paying more for the same, because we have the expectation that you're going to get more services out there to people." It really is just that language which says, "Nothing that we're saying in this letter separates you from the expectation that you will live within the resources that are on allocation for you." But they were having increased allocations.

M^me^ France Gélinas: So the increased allocation should allow them—I mean, the price of gas has gone up, so I'm guessing there will be pressure to increase the reimbursement for mileage and that kind of stuff. There is allocation that has been made that allows them to respond to those pressures?

Hon. George Smitherman: Yes. There are lots of pressures in health care. If you could grow at 12% or 14%, most people would like to. Those are not the numbers that we're contemplating here, but they're certainly numbers which are above and beyond inflationary pressures.

M^me^ France Gélinas: Okay. Then I'll go to point 5 of that same letter. I'll read it to you because, here again—

Hon. George Smitherman: I now have it too.

M^me^ France Gélinas: I also understand that point 5 of the guidelines to CCACs requires CCACs to inform the LHINs of any contract extension, and that the ministry has provided direction to the LHINs to guide them in these situations—I take it because of the moratorium etc. Are we allowed a copy of those directions that were given by your ministry to the LHINs?

Hon. George Smitherman: Yes, I would think that can be made available. The point that's important here is that sometimes existing service providers can't meet their volumes. So we can't constrain a LHIN by saying, "You can extend a contract," in the instance that that party which is currently contracted is already falling short of their service volumes, or in a circumstance where they say, "We've got to hold the line here, but we don't have another 5% of service volumes to give," or what have you. We just make sure that we don't constrain them so much that they don't have a suitable service provider. We're also making clear in point 5 that we expect CCACs to be working very closely and co-operatively with local health integration networks.

The more specific information that was in those directions etc., we'll have to look to pull up. That would be information that's being shared—I'm not sure who—perhaps by an assistant deputy minister.

M^me^ France Gélinas: Okay. So although there is a moratorium, there could be requests for a proposal in those situations where CCAC is—

Hon. George Smitherman: It's possible. It's obviously not our first choice, but we have to be pragmatic. Somebody has to provide the services. If a party is unwilling or unprepared to negotiate that in good faith, then we can't tie their hands to the point that there's no alternative. But to make it very clear, our first priority is continuing the existing relationships within the financial context that is set.

M^me^ France Gélinas: Does the ministry have a timeline as to when it plans to announce whatever process for home care service delivery will come after it was halted in Hamilton? How is the ministry determining what this new process is going to be?

Hon. George Smitherman: I wouldn't say that we have a—you can see that the timeline is roughly established by the contents of this letter. I think that the obligation—I've spoken about this in the House in answer to your questions—is that the ministry assembles advice, they provide it to the government, and the government will consider that advice. I don't have a timetable around that, but you can see that the parameters of the timetable are established in this covering letter.

M^me^ France Gélinas: Thank you.

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Hon. George Smitherman: We have a little bit of time to work with, and we want to make sure that we consider all of the best advice that's available. I've taken a lot of meetings on this subject and reviewed a lot of incoming correspondence. The ministry has been working very hard. I'm trying to offer good advice to the government. At a certain point we'll recommend something to the cabinet, and hopefully they'll agree and we'll move forward.

M^me^ France Gélinas: Okay. I guess I'll turn my question around. If there are groups out there that would like to have their views heard about how they would like the provision of home care services to unfold in Ontario, the way to do this is—

Hon. George Smitherman: I think that most of those groups will already have made their voices known by way of correspondence, which is one powerfully effective way to do that. I've said to you before in the House that I'm not going to commit to taking every meeting that people might want. That's not possible in my line of work. But I've taken quite a few on this, and they should make their views known through those mechanisms of correspondence, dealing with the people who they know are there, in the sector, and through their various members of provincial Parliament as well, because you are all very effective in raising the views and concerns that come forward from the community—through all of those avenues, I would recommend.

M^me^ France Gélinas: But there isn't an avenue specifically for this; it's the way you've explained it right now.

Hon. George Smitherman: Yes. There are many avenues to one destination point.

M^me^ France Gélinas: All right. We'll all get there.

Last Wednesday, when I talked to you about the release of the Sharkey report, you said, "I've had a high-level briefing with Shirlee Sharkey on the report." You hadn't seen the report, but you had been briefed on it. Do you know if there were any briefing notes or documents that were prepared for that briefing that you could share with us?

Hon. George Smitherman: The whole report is going to be released at 12:30 today.

M^me^ France Gélinas: Well, there you go. That's easy. Thank you.

The Chair (Mr. Tim Hudak): Good question.

Mrs. Elizabeth Witmer: That's with the Ombudsman too.

Hon. George Smitherman: I don't think they're doing it together, but it's possible.

M^me^ France Gélinas: I doubt it. I'm moving on to alternate procurement—I'm missing a word there—for hospitals.

Hon. George Smitherman: Alternate financing and procurement.

M^me^ France Gélinas: Alternate financing and procurement—sorry about that. When we talked to the few early—they were P3s, really, that were rolled out under your mandates, but we'll call them alternate financing and procurement. There's a lot of talk that some of the services are clearly health care services and will continue to be delivered by the hospital in a not-for-profit etc. Sometimes they're called ancillary services, or you're talking about parking and that kind of stuff, that could be run by the consortia that finance those hospitals and basically could be contracted out. Is this something that is the lay of the land in Ontario: There will be services that will be protected, stay with the hospital, and others that could go, if we're looking at the one in Ottawa, for example?

Hon. George Smitherman: I don't understand the use of the word "protected," and I don't really understand the question. Are you asking where the line is drawn that defines something as an ancillary service or not?

M^me^ France Gélinas: Yes.

Hon. George Smitherman: I think others will be able to offer views around that. As our AFP model emerged, of course the two hospitals, the William Osler and the Royal Ottawa, were, when I became Minister of Health, very substantially along the process. To have moved back from the process at that point would have meant a two-year delay at least in getting those hospitals done. The need was pretty pressing in those places, so we worked really hard to refine the agreement and to ensure that there was never any loss of control or transfer of ownership associated with it.

Despite what has been said, the mechanism is most closely described as a mortgage. I have one of those on my house—it's quite large—but I still feel like it's my house. When I go into the Brampton Civic Hospital, I know that we're paying it over a period of time, but I don't feel—my father passed on in the Peel Memorial, and I have some association with that hospital and with some of the people who work there. I still feel like that's one of our hospitals. But I do believe that as we moved into the refinement of that model, taking a look at North Bay as an example, we did make—the hospitals for a long time have had the right to make decisions around who provided what services. If we go back I think to the period of time when your party was in government, at Halton Health Sciences—I could dig up the information—I believe there were some services that were outsourced or privatized, to use that language. That's been the case for hospitals for a long time, but I think as the AFP model was refined for hospitals like North Bay and St Catharines etc., we did focus the RFP processes much more substantially on the buildings, if I could just put it that way. I'm not sure I'm answering your question perfectly—

M^me^ France Gélinas: No, you are.

Hon. George Smitherman: Romanow grappled with this: What is an ancillary service? As a Minister of Health for a long time, the place where the debates have become most engaged as far as I could tell is around housekeeping and cleaning. Some people take it to dietary etc., because those people have an interface with the patient. But the biggest debates that I've seen are around what is ancillary—and I don't think there's a clear line drawn around it—and that has typically been around housekeeping and general cleaning, some people getting right down to saying, "General access corridors, that's okay." There have been a lot of debates, but I don't believe there's one place where the line is expressly drawn.

M^me^ France Gélinas: But what you're telling us is that the new AFPs—where your government was clearly in charge from the beginning to the end, not the ones that were already there when you came into power—solely focus on the buildings, so we won't see the consortia being in charge of housekeeping, security, food services, portering etc., and the list goes on.

Hon. George Smitherman: Someone could speak more precisely to this, just to make sure that I've offered that in the most factually correct way. I think that might be recommended, but yes, I think that's right. Correct the record if I've overstepped it.

Mr. Ron Sapsford: There's no hard rule, as the minister has said. In a sense it depends on the hospital project that's being brought forward. So one hospital may in fact already have contracted out those services. They're presenting with a project which includes services that are already privatized. In general, in terms of current project load, most hospitals are not proposing that those kinds of services be included as part of the consortium. Most of them relate to the cost and the operation of the building itself: heat, light, power, maintenance, things that are directly tied to the operation of the building itself rather than the services that are provided by the hospitals. That's the general rule.

Hon. George Smitherman: "Maintenance" is a very important word in that context, because that's about staff who are playing the role of keeping the building in tip-top shape on an ongoing basis etc., but it was more narrowly defined as the processes move forward.

M^me^ France Gélinas: So there's no strict guideline. If the hospital decided to contract out let's say portering, there are no guidelines coming from the ministry saying that those services have to remain not-for-profit, public etc.?

Hon. George Smitherman: That's right. But please, you started your questions about the AFP model. Leaving that behind, I could confirm that the situation for hospitals is exactly as it was when the New Democrats were the government, which is that hospital boards have a substantial degree of latitude to make those decisions on a case-by-case basis in their own environments.

M^me^ France Gélinas: Okay, but it has not changed under the AFP?

Hon. George Smitherman: The AFPs do not encourage or allow the clustering of those services, but a hospital board has the right, separately, to make alterations in service delivery models within their environments.

On the word "guidelines" I think we'll have to make sure that—I'm not aware of any. That's not to say that there aren't any. We'll just make sure that there's no additional information we could provide that might be helpful. To the very best of my knowledge, that's the information I have.

M^me^ France Gélinas: Okay. On a completely different topic again, blister packs: Many health groups feel that those little packs improve health and reduce health costs by providing seniors with the support they need to take their medications safely in their own homes. We understand that the government is exploring whether to continue funding those blister packs. I'm just curious to see what kind of evaluation the government has or will undertake in terms of the health impact and the cost-effectiveness of blister packs before deciding the level of funding that will be available for that format.

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Hon. George Smitherman: No, I don't think that's accurate the way you've characterized that. Firstly, was it the Ombudsman? No, I believe it was the Provincial Auditor. Take a look at the Provincial Auditor's reports from the last two or three years on this matter: We got written up for allowing these practices, and there is a pending matter before the courts. I must be careful to acknowledge that.

It's not a matter of contemplation; it's an inordinately expensive solution and it is not one that is embedded in our estimates. I know that there's a lobby going on and I see the public postering that they've done up and down University Avenue. I leave my views about that kind of postering on University Avenue aside, but I have to be clear in saying that, as a matter of policy, we do not anticipate supporting it and we do not have the resources embedded in our estimates to pay for that.

We're currently paying about $700 million a year on dispensing. I don't have an estimate at hand except to say that it would be hundreds of millions of additional dollars to provide that service for every Ontarian.

The deputy will have some more info.

Mr. Ron Sapsford: Blister packs are one issue. The proposed regulation was really trying to deal with the issue of daily and weekly dispensing. As the minister said, in the auditor's report some concerns were expressed about the amount specifically for that purpose. The current amount on it is about $70 million in the ODB program.

Where we want to try to focus is the conditions around which daily dispensing and weekly dispensing would be covered by the ODB program. Whether the pills are packaged in a blister pack or not is in a sense beside the point. Some of the communication that's been going on, from the ministry's perspective, is a bit confusing over the difference between daily dispensing versus blister packs. I want to make it clear that the issue for the ministry is around the daily dispensing and not so much the blister pack.

We've been consulting with the field and we've had a number of responses. The ministry is reviewing that particular issue at the moment. At the completion of that, we'll move forward for discussion with the government. But I think it's important to understand that it's really about daily dispensing.

Hon. George Smitherman: More of my comments, as the deputy is being very nice in helping to disaggregate all of the content of my answer: The strenuous points I was making about the costs are on the implication around the number of prescriptions, not so much the material of the packs themselves.

The Chair (Mr. Tim Hudak): That is going to conclude the 20-minute segment. We have time in the morning session for the government members. If we do the full 20 minutes, we'll conclude at 10:44.

Hon. George Smitherman: Mr. Chair, just on that point: Is it possible that you might give me five additional minutes since I'm also Acting Premier today and haven't been briefed? Could we add five minutes to the afternoon or something?

The Chair (Mr. Tim Hudak): Yes. Do you folks want to stand down five minutes? Is that all right?

Interjection: We'll stand down five minutes.

The Chair (Mr. Tim Hudak): I'll end it at 10:39.

Mr. Kim Craitor: Minister, there are just a couple of questions I want to ask. One is regarding the family health teams. Before I ask you the question, I just want to share this with you: I remember, before I was elected, my doctor, a young fellow, decided to go out of practice and went into the pharmaceutical business. I guess there was more money there. So I was without a doctor for, I bet you, a year. I remember using telephone books and calling everybody.

Anyway, one night at city council I was kind of bemoaning the fact of what a challenge it is to find a doctor and, lo and behold, this doctor called me out of the

clear blue and said, "I'm taking patients and I saw you at city council. Even though you're a politician, I'll consider you."

The reason I'm telling you this story is that I went down to see him, and there were seven doctors working at this location, which I wasn't familiar with. It's on Queen Street in Niagara Falls. They have a pharmacy there. They actually do your blood testing there. They had a number of services, all collectively working together. It was great because, when he was away, there was always another doctor there. They're open on the weekends; they sort of rotate it.

The reason I tell you this is because I remember, shortly after being elected and sitting with you as the caucus, you were going over the family health team model. As I listened to it, I was thinking to myself, "That's similar to what I am fortunate to have in Niagara Falls, with the doctor who treats me and my family." So when you brought this forward as a model that we going to look at in Ontario, it's something I keenly jumped on because, in some small way, that's the kind of service I have in my community.

I know right now we're committed to about $53 million over the next three years with our family health teams. I just wondered if you wouldn't mind reiterating, Minister, for the record, the successes and the importance of the goals we have in going forward with the family health teams. In Niagara Falls, in my riding, we have two that have been approved that are going through. In Fort Erie, when I first came on board—and maybe thanks to some of your work, Chair—they were already in that process and were approved as a family health team and it's moving on. St. Catharines, I understand, also has one that's been approved. So they're very active in our area. Thank you, Minister.

Hon. George Smitherman: Let me offer a few things. Firstly, group practice: Ms. Witmer and I have an ongoing debate about this because she likes to pretend that family health teams are just renamed family health groups. But in point of fact, family health teams are substantially different because they add an array of allied health professionals that add to the comprehensiveness.

But no doubt, doctors working in groups is a really good starting point for the emergence of comprehensive care by adding an array of additional staff—the family health team. That's why I like to say that the family health team concept borrows substantially from community health centres, where you do find that comprehensiveness.

Just a few things that are important to know: Last year in Ontario, 83% of doctors who work in groups—which is the vast majority of our primary care doctors—took on new patients. They don't all put up their hand when the College of Physicians and Surgeons of Ontario asks them. They don't say, "Yes, I want to be known as a doctor who's taking on patients." But when we look at the data, 83% of them took on more patients.

It's that kind of commitment on the part of our doctors that has allowed us to get care out there to 630,000 more Ontarians. That's why the Ontario Health Quality Council has been able to take a good, hard look at the data that are available and conclude that there are 400,000 people actively looking for care. That's still a lot of people, no doubt. If it's one, it's too many, but the target of getting family health care for all that are looking for it is definitely within reach.

The family health team model has been an important contributor to that. To date, we have 1.8 million people in Ontario—patients, that is—who are receiving care in a family health team environment. That's going to grow in the next year or two to at least 2.5 million. The good news is that, of those, 180,000 were previously unattached. So as family health teams are expanding, they are also expanding their reach and taking in unattached patients.

I think the member for Northumberland–Quinte West has told the story about how the team—or perhaps it was the member for Prince Edward–Hastings—in Picton, which was a substantially underserviced community, has reached out and gotten care to everybody in that county, and now has gone up to Trenton and reached out and gotten care for 600 people who are associated with the air force base there.

1030

We really believe that the model is working to the point that we've actually started to look at how we can adopt the principle of interdisciplinary care to the other models where doctors are working, and we have some pilot sites in places like Hawkesbury and at Jane and Finch taking a look at how we can expand those principles.

We've got some family health teams that have not fully emerged, and we have 50 more that we're committed to. The first one of those is in Orléans, which we've announced and which the community has been working on for two or three years. Just to put it in perspective, 1,300 doctors and a pretty good ratio, heading towards one to one, where for every doctor who's there, you have an allied health professional. We have at least 800 who are hired already in those environments and many other approvals. So I think that's been very promising.

I'm giving you a lot of information and too many numbers, probably, but here's a really stunning one: In the last four or five years, the number of Ontarians receiving care from doctors in a group setting—not just family health teams, but a group setting of any kind—has had a sixfold increase. In March 2004, the number of patients receiving care from a doctor in one of several group settings was 1.3 million; in March 2008, it was 8.1 million. So there really is an extraordinarily strong foundation of physicians who are working in group practices, and that really gives us the opportunity to continue to expand their comprehensiveness by adding nurses, nurse practitioners and other allied health professionals.

We're in a pretty exciting spot, and I think many jurisdictions in the country would look to Ontario as a place that really is setting a good example. Madame

Gélinas talks about Quebec. They have a different model there for sure, but ours is something that really does offer good prospects for further improvement and gives us a chance to zero in on those 400,000 people whom the Ontario Health Quality Council says are out there actively looking for doctors.

Mr. Kim Craitor: Thank you.

Hon. George Smitherman: Memorize all those numbers.

Mr. Kim Craitor: Those are great numbers to have.

The Chair (Mr. Tim Hudak): We have about seven minutes, Mr. Craitor.

Mr. Kim Craitor: I still have a couple of other questions, Chair.

The Chair (Mr. Tim Hudak): Please go ahead.

Mr. Kim Craitor: I want to talk to you a little bit about diabetes. Again, sometimes it's a little personal around this table, but my wife's brother passed away and one of the causes was diabetes, and I have four friends who have been affected by it out of the clear blue.

Where my doctor is located, they've been working on their own with some ideas. When people come in and there's an indication they have diabetes or a possibility, they've actually been bringing them in on their own—something initiated on their own—and just sitting with them to try to educate them, make them aware that it's possible that they might be a candidate for it and just trying to share with them some of the things they should be looking at.

Having said all that, the reason I'm asking this question is because I was really keen and excited, and I hear from my own community about the fact that we've included in our budget funding for the implementation of a chronic disease prevention and management strategy around diabetes. So, just with the small background information I've shared with you, Minister, I have a bit of understanding why that is so significant. I know my doctor has sat with me and told me the numbers that they themselves project just for our own community, what they feel will be the number of people affected by this. Maybe you could just touch on that as well.

Hon. George Smitherman: Well, a few things first. When we use the words "chronic disease prevention"—they're not at the estimates process with us, but the Ministry of Health Promotion is our dance partner. So part of the strategy you will see coming forward will involve enhanced efforts and resources on their part to prevent diabetes. We've done a lot, but the numbers are breathtaking and startling.

Now, when I look at diabetes, I actually see challenges, that's for sure. You can't help it. You talked about the people—we all have those stories. In our first circle, in our families, with people we work with in our communities, we hear a lot about it. But the reason I'm actually enthusiastic about it is that, at present, the health care system expenditure is extraordinary for people with diabetes because it relates in a huge way to the comorbidities, to use a clinical term. The health care circumstances that people with diabetes get into are dreadfully impactful and take, on the human toll, in many cases the most extraordinarily expensive interventions that a health care system can have.

Look at chronic kidney disease: 51% of the people who require dialysis have diabetes. I can put a cost on that, but try to put a cost on having to go and be hooked up to a machine three or four times a week for three or four hours, where in some cases you've got to drive 98 kilometres. Then put a fiscal cost to it. That's why I see it as an opportunity.

I can't tell you everything about our strategy because I'm going to save some of that for the day of communication, but in the estimates process, you can see that we've got a lot of resources put together to implement a comprehensive chronic disease prevention and management strategy. What we want to do is learn the lessons of chronic disease management and apply them to diabetes first. They say, "How do you boil the ocean? One cup at a time." "How do you eat an elephant?" or something like that—not that I'm proposing that.

But we really think diabetes is the place to start because the indications touch so many things. For many people with diabetes, for it to be well managed, they need a lot of pieces of the health care system to be functioning well. Our diabetes registry, which will be forthcoming, is really the front-runner to the inter-operable electronic health record that we all speak about. That will emerge first as a benefit for our diabetic patients. At the same time, it's going to provide the practitioners with the computerization and the clinical prompts that ensure that no matter where you go, if you're a diabetic, you get access to the same advice and the same encouragement; that we build into the technology the capacity for co-management or self-management, because diabetes—and cancer too, in many ways—is a very big example to all of us. A health care system might be a safety net, and I spoke about that earlier, but no health care system is going to be able to address problems with a pill or some other solution that is anywhere near as powerful as human behaviour.

To be very blunt with you, for all that we're working to do and to enhance our health system capacity to address, if we don't get more citizens who are proactively engaged in the things that they can do to remain healthy—or if they do have diabetes, to be as healthy as they possibly can be—then the tied-in cost of this one chronic disease is extraordinarily frightening. I take the optimistic viewpoint and see this as the opportunity, the low-hanging fruit, because we're already spending $5 billion or $6 billion a year on the costs associated with diabetes, and much of it is being spent on the costly comorbidities: amputations, kidney disease and dialysis, heart disease and stroke. Many of these onset as a result of diabetes.

Doing a better and more effective job of giving the supports necessary to our diabetic folks and enhancing our efforts to stop people from acquiring diabetes through lifestyle choices etc. are all enormous parts of the strategy. Over the course of the next several months,

Ontarians are going to learn much more about the comprehensive approach the government is taking to this. I gave you a bit of a high-level overview of that.

The Chair (Mr. Tim Hudak): Thank you, Minister. I think we'll stop it there in the interests of preparation for question period.

There seems to be all-party agreement that we will meet at 3 p.m. to make sure we get through our time. There is a total of three hours and 10 minutes left in the consideration of estimates. We might have to find 10 minutes that we forgo to get done by 6 p.m. There will be a resolution, hopefully, in the House to allow us to sit at 3 p.m. to get it done today. That way, we don't have to worry about meeting tomorrow.

I remind members as well that after we finish estimates, we have a vote on the estimates. Only members who are permanent members of the committee or substituted in are permitted to vote in those sessions.

Folks, thanks very much, and hopefully we'll see everybody back here at 3 this afternoon.

The committee recessed from 1039 to 1505.

The Chair (Mr. Tim Hudak): Good afternoon, folks. I call the afternoon session of the Standing Committee on Estimates to order, back in session from our recess this morning.

I understand the three parties are working together on a rotation to ensure that we can finish a bit earlier and get through our estimates time. We'll start, as we finalize this proposal, with the official opposition. Ms. Witmer, you have 20 minutes to start today's session.

Mrs. Elizabeth Witmer: Thank you very much, and I have no doubt that the minister is going to answer every question now, since we're going to allow him to get out at 5 o'clock.

Hon. George Smitherman: I'll do my best.

Mrs. Elizabeth Witmer: All right. I know you have endeavoured to do so, and I appreciate it. Since we are winding up this afternoon, I would just begin by expressing my appreciation to the minister. I know that there is a lot of work involved in preparing for estimates. I'd like to thank the deputy and all of the Ministry of Health staff who are here today. I know that the answers to some of the questions we have asked are going to be provided to us at a later date and that it's a lot of work for staff, both the people who work with the minister and particularly for the people who work with the deputy in supporting the minister. I really do appreciate it. I know from personal experience that it's a lot, and I do thank you very much. I appreciate the responses that you have provided to me thus far.

I want to take a look, Minister, at Bill 97. I want you to tell me where in this bill it says that foreign doctors are going to be fast-tracked.

Hon. George Smitherman: The IMG? I didn't know its number. The meat of the bill, if you will, is in the definition of "public interest," broadening the definition so that colleges are obligated in part of their consideration overall, in the registration of not just doctors but foreign-trained health professionals, to take into consideration the impact, the public interest of not having access to physicians. In addition to the legislation, the meat, the substantial elements, are addressed through regulation, which we will be developing, working with the College of Physicians and Surgeons of Ontario over the course of the summer.

Mrs. Elizabeth Witmer: Right.

Hon. George Smitherman: So it's the combination of the legislation and the broadening of the definition around "public interest" and regulation, which we will promulgate over the course of the next several months combined, that is impactful.

Mrs. Elizabeth Witmer: Right, but I think we need to be clear. I sense that with the way that the communication has perhaps come out from your ministry, there is a little bit of confusion. Despite the name of the act, all that's happening here is that we're amending the Regulated Health Professions Act, 1991, and the bill basically says that schedule 2 is going to be amended by adding the following section, which is:

"Duty of college

"2.1 It is the duty of the college to work in consultation with the minister to ensure, as a matter of public interest, that the people of Ontario have access to adequate numbers of qualified, skilled and competent regulated health professionals."

There is absolutely no reference to any specific college. There is no reference to any specific health professional. It's simply a change that applies to all of the colleges and all of the health professionals. This bill certainly doesn't say that we're now going to fast-track IMGs.

Hon. George Smitherman: With respect, I think perhaps you haven't taken the opportunity to read the full ministerial statement which accompanied it.

Mrs. Elizabeth Witmer: Yes, I did read that.

Hon. George Smitherman: But I was certainly very clear, and in the press release as well it's very clear. It makes the point that it is the combination of the legislation and regulation that creates the impact with respect to the fast-tracking of IMGs. I don't have the press release in front of me, nor the ministerial statement—now I do. I think that it's very clear that the regulation process is included in that. I know that the ministerial statement was very clear on that point as well.

1510

Mrs. Elizabeth Witmer: Right, but at the end of the day, this is simply giving a duty to the college to work with you, the minister, to ensure that people have access to adequate numbers of health professionals.

Hon. George Smitherman: I'm not a lawyer, but I don't think that's actually the appropriate interpretation of the words that are there.

The circumstance at present, and the ministry has been informed of this by colleges over time, is that in the absence of this broader definition of public interest, the college is not obligated to consider the circumstances for a community that is without access to those health professionals. In other words, they might be taking those

decisions in the abstract. This is to put front and centre in the public interest section of the RHPA, the necessity and obligation of the colleges to consider the circumstances for patients or individuals in communities. I think it's very substantive on that point, and as you've made the point, it puts all colleges—not simply the matter for the College of Physicians and Surgeons of Ontario but all licensing bodies and colleges—on record with respect to the necessity of considering the broad public interest in these matters.

Mrs. Elizabeth Witmer: Okay, so just clarify it for me: There is no reference in this bill to the College of Physicians and Surgeons of Ontario?

Hon. George Smitherman: As you made the point, it covers all regulatory health colleges.

Mrs. Elizabeth Witmer: That's right. There is no reference in this bill to foreign-trained doctors, international medical graduates?

Hon. George Smitherman: No, we don't want to limit it simply to the college of physicians and surgeons or to the issue of physicians. We want to make sure that on a go-forward basis, all regulatory colleges, as part of their consideration of the credentials of foreign-trained professionals in the registration process, consider and be mindful of the underlying circumstances and deprivation for Ontarians associated with limitations in access. It's really a statement on behalf of the patients, to bring added influence of the patients' circumstances into the work of the regulatory bodies.

Mrs. Elizabeth Witmer: Okay. I appreciate that clarification. Will the Minister of Health or the ministry still have the responsibility of determining, for example, how many nurses are going to be necessary to meet the needs of people in Ontario, or how many doctors, and what specialties? Who will now assume that responsibility?

Hon. George Smitherman: When you use the word "still"—Dr. Joshua Tepper is not here, but until we appointed an assistant deputy minister for health human resources, I would have to say honestly that I don't think the Ministry of Health had emerged to the level of sophistication that your question suggests.

You used the word "still." If the Ministry of Health and Long-Term Care over a period of decades had been set up to be very effective at forecasting health care needs, then it's hard to imagine that previous parties would have shrunk the size of medical schools or been slow in responding to the need to expand them. I don't mean to be combative on this point, but what we have emerging for sure is a health human resources capacity within the Ministry of Health that is much more effective at projecting those very needs that your question gets at.

Because Dr. Tepper has a co-report or a dual report to the Ministry of Training, Colleges and Universities, he's also ideally placed to work with that ministry because it's also responsible as the production line for the health professionals that we need.

Sophisticated health human resources planning is our job for sure, and it's emerging that we're better able and more sophisticated to do that than the ministry had been historically, the best I can tell.

The deputy, who's had a lot of experience, may have a take on that, but when I arrived there, I have to confess, and I've said this publicly hundreds of times, I really didn't feel, as important as that issue is, that the ministry was—the nursing secretariat, there'd been some work done here and there, but overall I really don't feel that health human resources planning had met a sufficient test in terms of its sophistication. We've been working to add to that quite dramatically. Dr. Tepper is a pretty active piece of that puzzle, for sure.

Mrs. Elizabeth Witmer: I just want to set the record clear on one point. You know what? We can go back and blame Bob Rae, when he was Premier, for cutting the number of doctors, but that's not honest. The reality is that across Canada a decision was made, for whatever reason, to do so, and when it was discovered that that was a mistake, obviously people started to do things a little bit differently.

I think you've answered my question. I guess it's not going to be left up to the colleges to make a decision as to the appropriate number of professionals. For example, right now some of the reasons we don't have specialists in areas where we probably need to have them is because they're not appropriately remunerated. For example, people want to be a pediatrician but nobody wants to be a geriatrician. Who's going to take a look at that to determine—with an aging population, I know this is one area of shortage. How are we going to address that?

Hon. George Smitherman: On the point you were raising with respect to the decision that the Rae government took, I think what you're referring to is that the Mulroney government at that time sent out a—

Mrs. Elizabeth Witmer: It was across Canada. It doesn't matter. But I'm not going to—

Hon. George Smitherman: With all due respect—

The Chair (Mr. Tim Hudak): One at a time. Let the minister respond.

Hon. George Smitherman: With all due respect, it does matter a bit. It's not like the government of Canada offered binding direction to provincial health ministries to cut the size of their medical schools, and I don't think it's accurate to suggest that every province followed that. But yes, of course, there was a report that the Health Canada folks disseminated to people that said, "Oh, looking for a way to cut the growth in health care costs? Produce fewer doctors." Obviously we're still paying a price for that decision, because the physician production line does take quite a long time.

Just on the issue about specialties and the like, when I arrived in the ministry, no one was taking the residency positions for family medicine. Not only have we made sure they're being filled, we've substantially increased the proportion of them. How did we do that? Through our agreement in 2004 with the docs, we substantially enhanced compensation across all platforms. We took the caps off specialties, and in family practice we sub-

stantially enhanced the compensation. We're back at the table right now, and though I can't—

Mrs. Elizabeth Witmer: I know.

Hon. George Smitherman: As you're well aware. The issue of geriatricians, one specific example that you've raised, is well known to both sides and a matter of discussion in that context. We're always looking to try and address those imperfections.

Mrs. Elizabeth Witmer: Okay. I appreciate your responses there and I'm glad we're looking forward to the future to see what health professionals we need for our population.

I wanted to take a look at e-health. We attempted to access the province's e-health strategy online, but all we got was an online directory for the e-health program. I'd like to know why that strategy wouldn't be online, and if it's not, could we get a copy?

Hon. George Smitherman: I can tell you that there will be a lot of action forthcoming on that matter. Some of it is still a matter of consideration before the cabinet. We have done some policy work since the election, but we wouldn't be complete in our approvals process yet and that's why you wouldn't have all of that information available.

I could tell you further, though, that the diabetes registry, which I had a chance to speak about this morning, in terms of the earliest expenditures, a substantial additional investment in the development of the diabetes registry is going to be a big part of that e-health focus. I could just tell the honourable member that within the next few months, substantial additional information about the e-health strategy overall—the diabetes registry is a really crucial part of it—will be forthcoming. But the reason that information isn't presently in the public domain is that it's still subject to some work and to some cabinet-level approvals.

Mrs. Elizabeth Witmer: So are you saying that there's not a copy of the province's e-health strategy available for us right now?

Hon. George Smitherman: Yes, that's what I'm saying.

Mrs. Elizabeth Witmer: When do you anticipate that it would be ready for the public to view?

Hon. George Smitherman: Once it's completed all of its cabinet level approvals.

Mrs. Elizabeth Witmer: We're in June right now.

Hon. George Smitherman: A period of a few months, but I don't have a specific date.

Mrs. Elizabeth Witmer: You think in the fall?

Hon. George Smitherman: I think by the fall, yes. Perhaps even later on in the summer.

1520

Mrs. Elizabeth Witmer: In the 2008 budget, there was an investment of $47 million increasing to $239 million in the 2010-11 in e-health systems, such as diagostic imaging etc. How much of the investment will go to diagnostic imaging, and when will this money start to actually flow out the door?

Hon. George Smitherman: I don't have a specific breakdown on that available. I'm not sure if the deputy has any further information on that.

Mr. Ron Sapsford: The diagnostic piece of it in 2008-09, of the total amount—anticipating about $40 million.

Mrs. Elizabeth Witmer: About $40 million, okay.

Mr. Ron Sapsford: That's for the repository for the results of diagnostic testing. They're usually called picture-archiving systems. We have a number of them in place in the province now, and I think the provincial plan called for a total of eight, so this is a continuation of an investment to make sure that all areas of the province have access to this picture-archiving technology. That's the portion for 2008-09.

Mrs. Elizabeth Witmer: And that will start to flow later this year, then, Deputy?

Mr. Ron Sapsford: Yes.

Mrs. Elizabeth Witmer: What about the investment that's going to go to the diabetes registry, which the minister referred to? Again, when will the money start to flow? I think we've heard that there's work that's being undertaken right now. I know it's long-awaited. How much will actually go to the registry?

Mr. Ron Sapsford: Most of the work going on now is internal to the ministry, dealing with questions of architecture: What's the size and shape of it? What are the information requirements to support the registry at the front-line clinical area? A lot of the work going on now is preparatory to actually then moving out and designing the specific information technology. Time frames around it will be over the course of the next year for those investments to proceed.

Mrs. Elizabeth Witmer: So when would we see the registry, then, eventually?

Mr. Ron Sapsford: Excuse me, sorry?

Mrs. Elizabeth Witmer: When would the registry be up and running?

Mr. Ron Sapsford: We're targeting April of next year, 2009. But in doing that, that's a very ambitious agenda. We're trying to—as the minister has said, this is the priority for the beginning of e-health investment, and that's the target we've got at the moment.

Hon. George Smitherman: We should make the point that in order to implement the registry, the necessity is for the advance of computerization into all family health care environments. We know that the uptake on technology to date has been somewhat limited, so some elements of this are also the context of the conersation ongoing with the OMA.

Mrs. Elizabeth Witmer: Okay. That leads me to a question. I was in conversation with a specialist the other day who was lamenting the fact that his office wasn't computerized and ready to go online and that there was no money available. Is there going to be money available in the future to make sure that all of these people in the health care field can be connected?

Hon. George Smitherman: I can say in the future, yes, and to the word "all," yes, but on a phased basis. In

your campaign platform, you committed to have the fully functional, inter-operational, electronic health record by 2014. Our campaign commitment said 2015. Our earliest advances are designed, with the diabetes registry as the thrust, to enhance that computerization across the breadth of family health care or primary health care environments.

You mentioned a specialist. I can say yes, but on a phased approach, we really seek to enhance the benefits, at the primary care level, of having a diabetes registry which can also offer clinical guidance and prompts. So on a phased basis, yes.

The Chair (Mr. Tim Hudak): That's going to conclude the first segment of time for the official opposition. Thank you very much.

There seems to be—I'll check here—all-party agreement to have the following rotation: We began with 20 minutes by the official opposition, 20 minutes by the third party, 10 minutes by the government members. That will be repeated, and then the conclusion will be 10 minutes by the official opposition and 10 minutes by the third party. That will help us conclude by approximately 5 p.m. All agreed? Agreed. Terrific.

Thank you, and now we go to the third party. Madame Gélinas.

M^me^ France Gélinas: My first question, and I know that you've already talked about it this morning, is about the out-of-country treatment program. The only piece that I still wanted an answer on was how many people had applied, let's say last year, or data as recent as you have, and of the people who have applied, how many applied to receive funding after the fact, as in they already got the service and then applied—

Hon. George Smitherman: You mean retroactively?

M^me^ France Gélinas: Yeah.

Hon. George Smitherman: I would hope that we don't keep stats on that, because that's not the way the program works.

M^me^ France Gélinas: No, I know.

Hon. George Smitherman: I really think it's unrealistic to expect that there could be such a program where you can go and acquire a service without any approval and then bring the bill back home. So I doubt that we have such stats, because I assume there's a form letter that says, "I'm sorry, that's not the way the program works." I think the deputy mentioned this morning that we try to enhance through communication to all of the physicians, who are important because they sign the paperwork, to refresh their memory about the necessity of this being pre-approval and no alteration. I don't anticipate any alteration in that element of the policy.

M^me^ France Gélinas: Okay. Then how many have applied and how many have been successful versus turned down?

Mr. Ron Sapsford: For out-of-country?

M^me^ France Gélinas: Yes, coverage.

Mr. Ron Sapsford: Well, because we have the projects in place, the trials and the registries for PET scanning—

M^me^ France Gélinas: No, I'm not talking about PET. I'm just talking about—

Hon. George Smitherman: Overall, out-of-country, total applied—

M^me^ France Gélinas: —people who applied for the out-of-country treatment program.

Mr. Ron Sapsford: Oh, you mean any out-of-country?

M^me^ France Gélinas: Yes.

Mr. Ron Sapsford: I'm sorry, I misunderstood.

Hon. George Smitherman: We may not have that at hand, but that's information we'll be able to get to you. I assume that the Health Services Appeal and Review Board makes note of such numbers in their annual reports, so we'll get that information.

M^me^ France Gélinas: Okay.

Mr. Ron Sapsford: So that would be applications for pre-approval?

M^me^ France Gélinas: That's right.

Mr. Ron Sapsford: We can get that.

M^me^ France Gélinas: If you have anything on people who were a little bit late and went at it too late, let us know also.

Hon. George Smitherman: If we have any stats on that, we'll provide that as well.

M^me^ France Gélinas: The other one has to do with the northern health travel grant. Coming from the north, I hear a lot about it. We still have complaints of people who say from the time they submit their request for reimbursement to the time they receive their cheques, there are still big gaps. I was wondering if this is something that is being monitored, and if it is, if we could have information on this as to the delay between the time the ministry receives the request for reimbursement and the date that the cheque is mailed, I guess.

Hon. George Smitherman: Two pieces of information: This year, the program goes up by $17 million because, as you know, last year we made two enhancements: on the mileage, per kilometre, and on accommodation. Part of the investment this year is $1.4 million to upgrade the computer system, which is why we're not responding as promptly as we should. So we know it's a problem, and the investment that we're making in the computerization is designed to enhance the performance of the response to the applications. I'm not saying that well, but to shorten the timelines for a response. We know we're not doing our best work there yet.

M^me^ France Gélinas: Okay. But do you have actual figures as to how long it takes that I could have, or it's more—

Hon. George Smitherman: We wouldn't have that at hand, but yes, we would have some service records. We could try to offer, as well, what our hope would be in terms of the investment we're making, what kind of a standard in performance improvement we might be able to offer to residents of the north.

M^me^ France Gélinas: That would be good. My next question is on the new dental program. The budget identifies $45 million over the years. It was indicated that these funds would extend the child-in-need treatment to children up to 18 years of age, starting in 2009, and deliver prevention and treatment services for low-income Ontarians. I'm just curious as to the status. Are we still on track for 2009, and for people over the age of 18, is there an announcement planned? How many low-income Ontarians are you targeting with this program that you figure will receive assistance?

Hon. George Smitherman: Well, I can tell you that yes, it's right that the investment of additional resource is $45 million each and every year. All of the program criteria have not been landed yet and have not gone through the cabinet committee and cabinet approvals process. So while we have been working on it very vigorously, I have to confess that we're working as hard as we can to fashion those resources in the most effective way. As you well know from your experience in this area, $45 million is a lot of money; we all have to agree. But in an area of need like this, you could spend more. So we're working really hard to try and make sure that we have as sensible a program as possible, which also places appropriate emphasis on the opportunities for prevention and takes advantage of the enhanced scope of practice of dental hygienists. But I could tell the honourable member that it would be a few to several months before we would be in a position to make a final announcement about the program criteria. That would allow us, at that point, to answer more questions that you've asked about the quantum of people to whom we would hope to be able to expand coverage to.

1530

M^me^ France Gélinas: Okay. And for children, to bring the age up to 18, are we still on target for 2009? I think it's January 2009.

Hon. George Smitherman: I think that the approvals with respect to the expansion of the CINOT program would be part and parcel of the overall approvals process. But I would say cautiously, yes. I don't want to prejudge. It proves to be a very complex program to develop. I just want to remind the committee members that although I'm speaking about it, it does not yet have all of its cabinet-level approvals. I still have a little more work to do on that program before it would carry forward, but we've been working on it very vigorously and many ministry staff have been deeply engaged in helping to develop it.

M^me^ France Gélinas: I'm also interested in what I call complementary medicine. I was wondering if there was a policy framework for improving and regulating access to complementary health care in Ontario. Is this something that is being worked on right now with your ministry?

Hon. George Smitherman: I think that most people would look at our government as one that—you know, when I became the Minister of Health, HPRAC was defunct, so we got a new chair, we constituted a board and we got them set up with an office. The first thing they had to do was fulfill the statutory obligations of filing annual reports from prior years. Now they've done—I don't know how many reports HPRAC has done for us. They've been working at an extraordinary clip. You know from the health system improvement bill that we did move forward with substantial regulation of additional complementary practitioners, and we're continuing to work very hard with each of them on building those new colleges. We always ask HPRAC for advice around regulation and also around scope of practice, and that informs legislation. We are, I must confess, knee-deep in the building of the colleges that our previous legislation has called for.

M^me^ France Gélinas: So that would be to allow them to practise. Is there also a budget line that I could look up some place?

Hon. George Smitherman: No. It's a matter, at present, where it's about regulation but not—so we're regulating them to kind of put the stamp of regulatory approval with the colleges so that people can have confidence that said individuals are practising as part of a professional group. But they do not enjoy a budget line or funding access in the context of OHIP.

M^me^ France Gélinas: But thinking of the family health teams, if one of the teams was to request such a practitioner, would they get funding?

Hon. George Smitherman: No—very, very unlikely. It does speak to the platform that the family health team can be to continue to add a wide variety of providers to enhance comprehensiveness. But our family health team approvals to date have been quite specifically focused on—I think you went through most of these yesterday or last week—a range of providers: nurses, nurse practitioners, being kind of the top two; mental health workers; dietitians etc. We have not ventured as far afield as the opportunities regulated health professionals would offer us. We see the opportunity, but there are financial constraints around our ability to maximize that full potential.

M^me^ France Gélinas: I'm moving on to needle safety regulation. I know it's a joint project between the Ministry of Labour and the Ministry of Health and Long-Term Care. So far in the act, the new sharps are to go to additional health care workplaces by April 1, 2009. The regulation lays it out. I'm just wanting to know, are we still on time and on target for this?

Hon. George Smitherman: Yes.

M^me^ France Gélinas: We are. Okay.

Hon. George Smitherman: To the very best of my knowledge, yes. I'm getting a confirming head nod from my deputy too. Either that or he's nodded off.

Mr. Ron Sapsford: If the regulation says April 1, 2009, then it will be.

M^me^ France Gélinas: Well, hospitals are September 1, 2008. The hospitals are coming way faster.

Mr. Ron Sapsford: Yes.

Hon. George Smitherman: Yes, because what we did in structuring the phase-in was take some advice around where the intensity of risk was. We started in those envi-

ronments that had the highest degree of risk associated with them. I'm pretty sure that was the logic about how we structured the implementation of that regulation.

M^me^ France Gélinas: Hospitals are September 1. Long-term-care homes, designated psychiatric facilities, labs and collection centres are April 1, 2009. The list goes on, but we're on target for all of those?

Hon. George Smitherman: Yes.

M^me^ France Gélinas: My next question has to do with acquired brain injury. Do we have a registry as to how many Ontarians with acquired brain injuries are receiving treatment in ABI treatment centres and the ones who are on the waiting list to receive ABI treatment?

Hon. George Smitherman: We have a registry at Hamilton Health Sciences. I don't know well enough to say that it answers all of the criteria you laid out there, but we do ask Hamilton Health Sciences to assist us in tracking those patients for whom we need to get additional services.

M^me^ France Gélinas: That's province-wide?

Hon. George Smitherman: Yes, they play that role as the province-wide leader. Over the course of the last few years, we've made a lot of investment in acquired brain injury when you look at it on a percentage basis. We're getting new clients all the time from a variety of different things that lead to acquired brain injury.

For this year, we're investing an additional $7.9 million—some of this will not be in the public domain yet. We have $1 million that's being flowed, that I think first came forward in 2007-08, but a total additional investment this year of almost $8 million, which since 2003 will bring us to about a 55% increase in supports for ABI.

Some of it is for an across-the-board stabilization increase for all providers, and $4.8 million of it is to address those clients who are captured on registry by Hamilton Health Sciences. Then $1 million is for further capacity improvements across the network of community-based services for people with ABI.

M^me^ France Gélinas: Do we track the wait times that people are on waiting lists through this?

Hon. George Smitherman: I'm not sure the extent to which that's a feature of that registry, but we could get you some additional information about what the registry consists of and what data sets it captures.

M^me^ France Gélinas: If it does capture average wait time, I would be interested in knowing.

In long-term-care facilities, there are people with acquired brain injury. There are also people with developmental disabilities. Do we have a picture as to—for now I'll start with how many ABI and how many developmentally disabled people live in our long-term-care homes.

Hon. George Smitherman: It wouldn't surprise me if we have some data on that. I have never seen it or been made aware of it, but we will research it and see what we can find.

M^me^ France Gélinas: Okay. The other one that I would be interested in is, do we have a breakdown as to the age of the 75,000 residents of long-term-care homes?

Hon. George Smitherman: In the same vein, we'll look for that information as well.

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

Hon. George Smitherman: I think there seem to be more young people. I've been in a lot of long-term-care environments, and it's not like I'm seeing overall a tremendous number of young people, but I have a family member who's less than 30 and is in a long-term-care home, so I'm obviously aware of the experience.

1540

Many people are suggesting that it would be good if the ministry could think about ways, more possible in the urban areas, where we could begin to kind of cluster some of those patients who are below a certain age because the programming that they desire or that would be most effective for them might be different than that for more of a geriatric population. I think that's an idea that certainly merits consideration. But we'll see what stats we have available on those questions that you raise.

M^me^ France Gélinas: My next one is about breastfeeding. I'm guessing everybody knows about the baby-friendly initiative. It's a global program of evidence-based best practice standard and policy to increase breastfeeding rates. I know that it's established in about 20,000 hospitals worldwide, but what I don't know is how many hospitals in this province are accredited with this program. Is this something that you ask a hospital to report on? And are there other initiatives that the ministry does to encourage breastfeeding?

Hon. George Smitherman: I think that for our part, when we look at the province-wide system support, we look to public health units. The issue of accreditation of hospitals on that standard I'm not familiar with, to be very honest with you. I don't know if the deputy has any additional information.

Mr. Ron Sapsford: I know what it is. We don't have that information; we don't collect that information from hospitals directly.

M^me^ France Gélinas: I know some hospitals that are. We don't know system-wide?

Mr. Ron Sapsford: No.

M^me^ France Gélinas: The effort to help encourage breastfeeding is mainly focused through the resources in the public health unit, is what you said?

Hon. George Smitherman: Yes. Well, I mean, that's where I know it's a foundation across the province. Just anecdotally, I am aware that hospitals additionally, some of them, provide enhanced support for breastfeeding, but I don't know specifically enough about whether or how many of them would have signed on to this international protocol.

M^me^ France Gélinas: Is your ministry doing anything else or anything new or is there something coming to further encourage breastfeeding?

Hon. George Smitherman: We have no planned expenditure initiative or policy initiative in that area, to the best of my knowledge.

M^me^ France Gélinas: All right. I'm moving on again: Lucentis, a drug everybody knows by name now. When

the government announced that it would be covering the cost of the drug, many Ontarians were concerned that they would not be eligible, although it was recommended by their ophthalmologist. Can the minister tell us how many Ontarians have received coverage and how many have applied to be covered but have been rejected?

Hon. George Smitherman: I think that Helen Stevenson, who's the assistant deputy minister and responsible for the drug secretariat—I never remember her title perfectly well, but she'll remind us—could speak about this. I think it would be helpful just to set the record straight, because I think at the point that we announced Lucentis, there was a lack of clarity; it could have been clearer, and there was a little bit of confusion. Just to put on the record exactly how the approvals process for Lucentis works and then whether we have any of those stats yet, I'm not sure, but Helen is in the best position to tell us.

The Chair (Mr. Tim Hudak): Just identify yourself for the record, please.

Ms. Helen Stevenson: Helen Stevenson, assistant deputy minister and executive officer of Ontario public drug programs.

Lucentis was reviewed by our committee to evaluate drugs, which I had referenced on an earlier day. We then made the decision to fund the drug. The drug is funded as what we call a "general benefit" on our formulary, which means that there are no restrictions whatsoever placed on physicians to prescribe the drug. We did in our formulary put some guidelines or notes, which is, I'd say, common, in that when our committee does bring forward recommendations, they're often recommending where its use is most cost-effective. We did have those guidelines, but again, we funded the drug on a general benefit basis, meaning that all physicians could use it. To date, we've actually answered, I'd say, because of the confusion that there was, hundreds of letters directly to both patients and to ophthalmologists. While I don't have the exact numbers of how many claims we've had, we could certainly get them, but we are not having any more cases of patients writing in or expressing concern that they're not getting Lucentis.

The Chair (Mr. Tim Hudak): That does conclude our time for this 20-minute segment. You'll have to revisit this issue. Assistant Deputy Minister, thank you very much.

We'll now go to the government members. As part of the agreement, you have 10 minutes. Mr. Craitor.

Mr. Kim Craitor: I have a question, but could I ask Helen—

Hon. George Smitherman: To follow up on the Lucentis question?

Mr. Kim Craitor: Yes. Do you mind?

Hon. George Smitherman: No. I think that it would be very beneficial, to be honest with you.

Mr. Kim Craitor: Lou, do you mind?

Mr. Lou Rinaldi: No.

Mr. Kim Craitor: Okay, thanks.

Mr. Lou Rinaldi: It's your question.

Mr. Kim Craitor: I had a couple of questions, and I'm glad you brought that up. Just so it's perfectly clear, there is no age restriction on this?

Ms. Helen Stevenson: Just to clarify, then, on the program: Ontario public drug programs comprise essentially four programs, the largest of which is the Ontario drug benefit program, and within that is a program called the Trillium drug program. So essentially, among all of the programs, it's possible for any Ontarian to access a drug. If it's the ODB program, the Ontario drug benefit program is for people 65 and over, as well as people receiving social assistance, people in long-term-care homes etc. If they don't qualify through that, any Ontarian can apply for drug coverage through the Trillium drug program—

Hon. George Smitherman: For a listed drug.

Ms. Helen Stevenson: For a listed drug that is funded by us. That Trillium drug program is an income-based program, so if your drug costs are a certain percentage of your income, you can apply and have one of the drugs. Again, it is the same list of funded drugs that we fund for Ontario drug benefit recipients that we fund through the Trillium program.

Hon. George Smitherman: Just on the age bit, if an ophthalmologist says, "This is a—"

Ms. Helen Stevenson: Right. So if a 35-year-old needed Lucentis and it was someone whose income was low in proportion to their drug costs, they could apply for coverage through the Trillium drug program.

Mr. Kim Craitor: And if they were 66, they wouldn't be denied because of their age?

Ms. Helen Stevenson: They would then qualify through the Ontario drug benefit program.

Mr. Kim Craitor: The final question is: What is the cost for putting this drug into the program? What's the yearly cost?

Hon. George Smitherman: We're going to give you an answer, but we're going to just say that we have mechanisms now whereby we do negotiate with the providers. We might not want to offer every number that gives insight into the nature of those negotiations, but I think that we could offer some quantum. What is the effect, over two or three years, of putting Lucentis on the formulary?

Ms. Helen Stevenson: The number that we provided in the announcements was a three-year investment of over $100 million. It is over that amount. We did, as the minister stated, negotiate a significant discount on that, which is part of these confidential agreements that we now enter into with manufacturers in order to fund drugs.

Mr. Kim Craitor: Okay. Thank you very much. How much time do I have?

The Chair (Mr. Tim Hudak): You have seven minutes remaining.

Mr. Kim Craitor: Oh, good. Okay. I have a seven-minute question to ask you, Minister. I talked to you earlier about the family health teams, and I want to talk to you about the community health centres. What I want to quickly share with you is, I remember when I was first

elected and I travelled—as an MPP this time—through the hospitals, and oftentimes I would go downstairs and sit with the staff and have coffee. "How are things going? Can you give me advice?"—the new guy on the block.

I remember sitting with the nurses, and they would constantly tell me this: "The best advice I can give to you as an MPP is, what you should be doing is going up to your government and telling them to charge $10 when a person comes into emergency." This is what they're telling me; I'm not saying to do this. I was asking: "Why would we do that? That doesn't make sense." And they would say to me: "Kim, if you were here all the time like we are, we're telling you that there's a large proportion of people who really shouldn't be coming in here, but we see them. It's not an emergency hospital the way we knew it, as nurses who have been here for 10 or 20 years. There has to be some other mechanism where they have some opportunity maybe to go somewhere else, rather than keep coming in here, whether they've got a high fever or a cut that needs a couple of stitches—but here they are." Or in some cases, doctors would just say, "Go to the emerg. I can't see them because I'm busy, so I'll send them down to the emerg." I'm listening to the nurses telling me this while I'm there.

1550

Then we came up with the community health centres. I'd like you to just comment on the role they're going to play in the communities. We have one in Niagara Falls that is going forward, Fort Erie and Port Colborne have one that's been approved and I know St. Catharines has one. That's a big investment and a big commitment.

Hon. George Smitherman: Let me talk about community health centres in the context of emergency rooms. Let me say, firstly, one thing we celebrated today in north Hamilton—we've just provided an almost $16-million grant for a new community health centre. This is an issue I think is probably quite well known to Madame Gélinas, who in her prior life ran one of these community health centres. Our government is basically doubling the number of investments that we have in the province of Ontario. It's one element of a strategy, along with family health teams and enhanced primary care through physicians' offices, to get care for people in the most appropriate setting.

A lot of people go to an emergency room in Ontario to get a prescription renewed, which I associate as the equivalent of taking a Bentley to a demolition derby. We've really got to stop this pattern—which is blowing our brains out fiscally—of using a high-end resource for things that are much more appropriately done in other settings. Of course, you can't fault the patient too much if we haven't actually aligned ourselves in a way that gives them the access they need. So our approach with community health centres is similar to the approach with family health teams and it's all about building up appropriate capacity in the community so people can be conditioned to use the appropriate health care service for the appropriate need.

As we move forward with the work of Dr. Alan Hudson, as we bring our award-winning wait time reduction approach to the issue of emergency rooms, which really has bedevilled health care off and on for the last few decades, we're going to be focusing all the more on getting people accustomed to seeking care in the most appropriate way. We're going to develop something called an urgent care continuum, which is going to help to educate folks around where the most appropriate place would be to access care in the circumstances they're in.

Let me mention a number from earlier this morning. I mentioned that in the primary care models, where doctors are working in groups, we have nearly nine million patients. That means those patients have access to physicians, even if it's not their own and even if it's after hours. One example of how we've got to do better is to maximize the utilization of physicians practising in those models and try and divert as much traffic as possible from the emergency room environment.

The Chair (Mr. Tim Hudak): Two minutes left

Mrs. Amrit Mangat: Minister, I know this government has made significant investments in long-term health care reform since 2003. Can you tell me how quality and staffing in long-term-care homes has improved as a result of our investments?

Hon. George Smitherman: Today is an interesting day because we had a press conference at 12:30 where Shirlee Sharkey, who has done a report for us on this very matter, has come out—I encourage people to take a look at it. At the heart of it, when we look to long-term care, we agree there needs to be more people working there. Through the investments that we've made over the last few years, we have more than 6,000 additional bodies—workers—providing care in the long-term-care environment. We've substantially increased the raw food allowances etc. But as we look to the next three years, we'll be investing a further $600 million to bring on at least 4,500 more staff, or the equivalent of 4,500 additional staff, as we continue to build up the amount of care that's available to our loved ones every day.

The report today also gives us encouragement about mechanisms that we can use to make sure that the dollars that we invest actually achieve the outcome and results that we all expect. We're going to ask the Ontario Health Quality Council to help us measure the satisfaction of the individuals who are actually receiving that care.

Mrs. Amrit Mangat: I'll move on to the next question. Can you tell us how you are investing in cancer screening programs?

Hon. George Smitherman: Cancer screening we've enhanced quite dramatically, and we've launched the colorectal cancer screening program. Other jurisdictions in Canada have done that following Ontario's lead. Building on a campaign commitment, we really feel that—we have breast cancer screening on the one hand and colorectal cancer screening over here—we have the capacity to bring these together and to formulate a world-leading screening capability in the province. We'll be bringing additional resource to the table to enhance our capacity.

Early detection of cancer is important. There are people sometimes who are fighting for their lives who

have not taken advantage, or have not been prompted to take advantage, of screening that is widely available. We'll also be funding the PSA test as of January 1, 2009. All of these things together are about enhancing a society's capacity to do screening, which is another way of saying to have early detection, which is in the family of prevention.

The Chair (Mr. Tim Hudak): That does conclude the time.

Interjection.

The Chair (Mr. Tim Hudak): Yes, no problem. We still have another rotation for the government members.

We now move to the official opposition. As part of our agreement, this is your last 20-minute segment, Mrs. Witmer.

Mrs. Elizabeth Witmer: This is the final?

The Chair (Mr. Tim Hudak): Your final 20-minute, but you'll have one more 10-minute.

Mrs. Elizabeth Witmer: Okay. I have a question here regarding an MRI in Lindsay. Apparently, the Central East LHIN has the highest MRI wait times in the entire province. They're waiting 110 days. The closest scanner, as you know, is in Peterborough, which has only a marginally better wait time of 96. So currently, these people are not well served in that particular area. Ross Memorial Hospital has drafted a proposal. It would bring that population into line with other communities in the province. So my question to you is, are you prepared to consider funding for an MRI at Ross Memorial Hospital in Lindsay?

Hon. George Smitherman: Let me say first off that it's nice, isn't it, to finally have some measures, because we didn't have this information just a few years ago. We need to use it well to inform our decisions well.

I would tell the honourable member that two other hospital corporations in the same LHIN, Lakeridge and Rouge Valley, also have some designs on additional MRI capacity using those same numbers. We have to take a hard look at all of that, and we have to take a hard look at where the population base is as well. More typically, of course, MRIs are being sustained in communities that have a pretty strong population base, but we're pretty mindful, yes, of the wait time overall in Central East and that it could use some benefit. But I would want to be very forthright in saying that, in addition to Lindsay, we do have some level of active request from those other hospital corporations in the Central East Local Health Integration Network.

Mrs. Elizabeth Witmer: Thank you very much. They do add here that they have already fundraised the capital expenses.

Hon. George Smitherman: That's great. That's obviously an important sign about the community support for that hospital, which is a good one.

Mrs. Elizabeth Witmer: Exactly. Anyway, we've got that on the record.

I'd like to move now into home care and the aging-at-home strategy. How much of the $700 million has already been spent?

Hon. George Smitherman: The aging-at-home strategy is $700 million over three years, or $1.1 billion over four. This year's budget, give or take, is $100 million. Of that $100 million, approximately $3 million to $5 million has been spent on the acquisition of 100 Dodge Caravans, which will soon be driving people to 135,000 appointments. Within a few days we'll be allocating the lion's share of that $100-million resource for this fiscal year. So today, a very small portion of $100 million; but within a week or two, substantial allocation to local health integration networks, which is then going to flow out and fund approximately 250 distinct initiatives around the province of Ontario.

Mrs. Elizabeth Witmer: Those initiatives that you talk about—what I hear you saying, then, is that so far you've bought the vans, and I'm sure they'll be very much appreciated. But no money has yet gone to patient care. You've mentioned these 250 initiatives: How much of that money will actually go to real people? How many people will be served and will really see a difference in their lives?

1600

Hon. George Smitherman: The program is about to launch, so it's fair to say that in a few weeks the whole storyline will have been altered. In the documents that local health integration networks have considered, they have taken stock of the dozens, hundreds and thousands of individuals who will be impacted by those. I don't have a quantum on those at hand, but through vigorous research and study of the investments that are made, we intend to be able to track the success of them, which will help to inform, because obviously the program is going to grow quite substantially over the next two years. So the tracking of those statistics is an important part of it.

There's one point I really want to emphasize: Right now, of 100% of aged individuals over 80 who are at home, about 20% receive some form of support. So enhancements to home care is one very important strategy. But as we seek to address the fact that, in the next 10 or 15 years, the number of seniors is going to double in Ontario, we're also seeking to enhance community capacity for programs that are essential to help to eliminate the barriers that people experience.

Aging-at-home dollars are not all about medical services being delivered to people in the home; some of it's about eliminating barriers: rides to appointments, Meals on Wheels, snow shovelling, light housekeeping, shopping, installing grab bars and those sorts of things. From the initiatives which will be funded in our first tranche of funding, we may be able to give you a quantum number of the additional Ontarians whom the approximately 250 initiatives are designed to have an impact on. We'll see if it's possible to bring that information together and provide it to you.

Mrs. Elizabeth Witmer: We did contact our local LHIN, and they had absolutely no idea as to how many people were going to benefit. I think it is important that we get that information.

I guess that leads me to another question. I'm going to jump—how many of the 70 recommendations that Elinor Caplan brought forward in Realizing the Potential of Home Care: Competing for Excellence by Rewarding Results have been implemented? How many of these 70?

Hon. George Smitherman: I just want to say that on the Waterloo-Wellington LHIN piece, it surprises me that they weren't able to offer you some of that. It may be that they perhaps just haven't tallied it, because in the reports that they submitted to the ministry with their funding proposals, they certainly delineated it. I've had a chance to look through vast reams of all of those. So I do think we'll be able to get you more information.

On the issue of Elinor Caplan's report, I'll have to either defer that to the ministry or to an answer that would be forthcoming. But in my experience, and I'm not sure if it mirrors yours, if I'm ever asked to write reports, I don't ever intend to make recommendations that number 40, 50, 60 or 70, because it's awfully hard to focus your attention on 70 distinct issues.

Mrs. Elizabeth Witmer: And that's why I'm saying: How many have and how many are left?

Hon. George Smitherman: We'll get you that information for sure. But even right from the get-go, I do want to let the member know that at the point that I released or responded to Ms. Caplan's report, there were a few elements—and I can't even remember exactly what they were. We didn't accept every one of the recommendations that had been on offer in the report that she prepared. We'll get back to you with a track of how we're doing.

Mrs. Elizabeth Witmer: Right, the number. Okay.

I want to jump over to emergency rooms. In your 2007 budget, you announced that, under the emergency department action plan, you would support the development of 1,750 new long-term-care beds and the replacement of 662 beds to help discharge patients from hospitals. How many of those beds have been developed and are now being occupied?

Hon. George Smitherman: You would know, from your previous work as a Minister of Health, that if we made an announcement in 2007, there aren't going to be any of those beds built and opened and operating yet. You have land that you have to run an RFP on, then the homes have to acquire the land, get the zoning and the building permits. The construction of a long-term-care home, on average, is 22 months.

As part of an earlier question, one of the things that we'll be tabling can show where those investments are occurring, and perhaps I could recommend to the deputy that we add a column which indicates what track it is on towards opening and provision of service. From recollection, many of those beds are designed to come to life in approximately 2010, so yet another 18 to 24 months before those beds are open. More recently, the local health integration network in northeastern Ontario made an allocation of beds in the community of Timmins which will not likely be in place until 2011. Typically, it's an announcement and then three or three and a half years, something like that, before you've actually got the product to life in a way that's supporting residents.

Mrs. Elizabeth Witmer: Okay. So you're going to give me a timeline and identify where these beds are going to be built—the new ones—and where the replacement beds are going to happen.

Hon. George Smitherman: Yes, that's right. On the replacement beds, they're in just two communities: in Thunder Bay, where the municipality wants out, so to say, on the delivery of care, and we've worked really hard on an exciting plan there; that's 300 of them, and about 145 beds in Windsor, where I think the facility called Malden Park wishes—

Mrs. Elizabeth Witmer: I know Malden Park.

Hon. George Smitherman: Okay. They wish to focus on other service delivery. Those are the two sites of the replacement beds.

Mrs. Elizabeth Witmer: So there's no further plan to replace the older long-term-care beds?

Hon. George Smitherman: That's a separate matter that I believe we addressed in an earlier period of estimates: the B and C redevelopment. The policy development work with respect to the B and C program is ongoing right now. It's anticipated that we would do that work through the balance of this calendar year. Our plan would be to have a program emerge that, over a 10-year period, renews 3,500 of the B and C beds each and every year, and that the local health integration networks would be involved in helping to determine priority bases. As we discussed, maybe they're going to want to bring together some beds on to one site, because the scale of the long-term-care home, the best practice or the standards, have obviously evolved quite considerably.

Mrs. Elizabeth Witmer: So, given the fact that these additional beds aren't going to be ready until, say, 2010 or 2011, how do you plan to deal with the people who need placement in a long-term-care home and currently cannot be accommodated? I know that you made some reference to that in an announcement recently, but where are we actually going to be able to accommodate people?

Hon. George Smitherman: At the heart of it, what you could see, even in last year's announcement—I think it was $142 million that you mentioned—there was a very substantial portion of resource which enhanced home care. So we do know that some people who are ALC today in a hospital bed could be at home with an enhanced degree of support. With the announcements that we've recently made, we are enabling that to occur.

There's also a school of thought—and I can't confirm—that suggests that up to 5% of those individuals who are presently in a long-term-care bed, with the level of support that we're now in a position to offer through CCACs, might even be able to return to a home environment or to an environment with one of their children, and the like. We will also be looking to pursue those kinds of strategies to maximize the benefit of the long-term-care asset.

Mrs. Elizabeth Witmer: Jeff Allan had a show last Friday, and although I didn't personally participate, I did

see the issues raised. I would say to you that the care of the elderly is probably one of the biggest issues facing communities in Ontario. In my community, people feel there is a shortage of beds, and I've heard from people in other parts of the province as well. So hopefully we can be in a position soon where we can assist some of our elderly to find appropriate accommodation, whether it's home care—what about the CCACs?

Hon. George Smitherman: Can I just offer one small comment there?

Mrs. Elizabeth Witmer: Yes.

Hon. George Smitherman: I think that there is also institutional bed-itis. There are circumstances where people who are not the individual, are not the patient, have concluded that building more beds is the answer to everything that bedevils us in health care. I got a very strong awakening from a group of seniors on that point very shortly after I became Minister of Health. We're working very hard to build more bed capacity but, at the heart of it, the number of seniors we have—which is, of course, advancing very substantially—they express in pretty crisp terms their desire to be supported to live on at home with dignity and independence. That's why we put so much stock in the aging-at-home strategy as it comes to life this week. But the needs are extraordinary, obviously.

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Mrs. Elizabeth Witmer: I agree with you. It's like hospitals: People believe that that's where they need to be. I think people do now recognize that sometimes they can be well treated and cared for in their own homes.

Hon. George Smitherman: If we had all the financial resources to build out everything that some people might envision, down the road, do we actually think that we would have the people, the human resources?

Mrs. Elizabeth Witmer: We don't.

Hon. George Smitherman: It's going to be a very tough situation that we're getting into with constraints around the labour force. These things are important to consider as well.

Mrs. Elizabeth Witmer: I don't disagree with you at all.

If I take a look at local health integration networks: Do they have any connection at all, or do you see them having any connection in the future, to the CCAC bidding process?

Hon. George Smitherman: In the questioning this morning from Madame Gélinas, we linked them at least somewhat, insofar as, because CCAC funds flow through and we've aligned their boundaries identically, this is a pretty strong hint from the government that we think they have a lot in common. I believe that the community care access centres are an aligned delivery agent for many of the initiatives of local health integration networks, but I don't know enough from your question to give you a good answer. Could you illuminate that at all?

Mrs. Elizabeth Witmer: Right now, the LHINs and CCACs are somewhat apart. What type of role do you see the LHINs taking in the whole bidding process?

Hon. George Smitherman: In the discussion this morning, it's really about enhancing their awareness of what's going on, but we anticipate that the CCACs would continue to have primary responsibility for running those bidding processes.

Mrs. Elizabeth Witmer: Do you plan to direct the LHINs to make future funding increases contingent upon hospital levels of efficiency so that efficient hospitals would receive more and less efficient ones less? And if not, why not?

Hon. George Smitherman: I'll ask the deputy to expand on this, but as a matter of principle, we sure are trying to create an environment where good behaviour is rewarded. You and I both know the storyline from health care about the CEO who's crafty and holds out. I think that behaviour has diminished a lot, but people are very mindful; they're watching for it all the time. We work very hard in the ministry to try to make sure that we're rewarding hospitals that are trying to do the right things.

I think that the deputy might be able to expand on that somewhat—not to put him on the spot.

Mr. Ron Sapsford: No, no.

Mrs. Elizabeth Witmer: You never put Ron on the spot.

Mr. Ron Sapsford: The discussion we had this morning about HBAM and the allocation models are part of the future direction for ministry funding policy. There is a strong element in the hospital community that believes that the allocations should recognize efficient operation and hence be reflected in the funding models, and the models that the ministry has used up until now are able to do that. However, there is a question about adequacy of funding. In some cases, there is across-the-board funding. It's a question, I think, of degree: How much of the funding should recognize efficiency as well as other operating pressures?

Up until this point, the LHINs have agreed until the end of 2010 fiscal to use the ministry's funding models for hospital funding. But there remains the question that part of the model of the LHINs is to give some degree of funding flexibility so that LHINs can be sensitive to the local needs of their own facilities. So the policy question that we'll be addressing over the course of the next period is: How much is allocated by formula versus how much flexibility does the LHIN have around the edges to recognize local hospital pressures? That's part of the future funding debate, but the allocation methodology is a fundamental principle of how the ministry would look at future funding.

Mrs. Elizabeth Witmer: I appreciate that response.

I know we're coming to an end. Minister, you've kept us so busy today that I have to run out again and do media interviews on all these issues that are front and centre in health care, but again, my thanks to you, Chair, and my thanks to people around the table.

The Chair (Mr. Tim Hudak): Just to make sure: You will have one more 10-minute—

Mrs. Elizabeth Witmer: Oh, do I?

The Chair (Mr. Tim Hudak): Yes, in your rotation.

Mrs. Elizabeth Witmer: Okay, that's good.

The Chair (Mr. Tim Hudak): That does conclude that set of 20.

Mr. Rinaldi has approached me for a slight change in the agreement, and I want to make sure members are satisfied with this. The government members have asked if they could take their 10 minutes last, which would mean that we go to the NDP, then back to the PCs, the NDP and the government members. It just gives them the time to wrap up. That's not uncommon at the estimates committee.

Hon. George Smitherman: Could I make a small recommendation? Would it be more helpful for Ms. Witmer to have her 10 minutes now?

Mrs. Elizabeth Witmer: No, it's fine.

Hon. George Smitherman: It's okay?

Mrs. Elizabeth Witmer: Yes, it's okay. Thank you.

The Chair (Mr. Tim Hudak): Is Mr. Rinaldi's request okay with everybody?

Mrs. Elizabeth Witmer: That's fine.

The Chair (Mr. Tim Hudak): Okay. To make sure we're clear: for the third party we have 20 minutes, followed by the official opposition with 10, the third party with 10 and then the government members with 10 to conclude.

Madame Gélinas, you have 20 minutes.

M^me^ France Gélinas: My first question has to do with nocturnal dialysis. I understand that the ministry is working with the 26 regional chronic kidney disease centres in the province to establish performance metrics and then work with the centres to determine the best approach to treatment distribution. There are a couple of questions regarding this. Could the minister provide us with some details about those initiatives?

Do you want all the questions now?

Hon. George Smitherman: I just want to say that whatever that language was that you just read, I'm not sure—that's somebody's analysis. I'm not saying it's wrong, but it's not at a level—and I've had two briefings in the last three weeks on chronic kidney disease. So that language is a bit foreign to me. I'm not saying it's not happening, but I could try and answer your question this way and then you could—

M^me^ France Gélinas: Sure.

Hon. George Smitherman: In the next three years, we anticipate that there are going to be 3,500 additional Ontarians who have CKD—chronic kidney disease—and require dialysis. We have a few hot spots in the province of Ontario right now—I'd say, five or six—where our capacity is severely outstripped: Ottawa, Ajax, Stoney Creek and especially in northwest Toronto—Brampton, northwest Toronto and up into the Central Local Health Integration Network. Our first step forward is going to be to enhance capacity in those centres, and the ministry is working very vigorously on the second piece of expansion, which would be to take advantage of a greater degree of nocturnal capacity.

But if we looked to northeastern Ontario—and I know that you've heard it. You've talked about this, the CBC in Sudbury has talked about this, and Rick Bartolucci has talked my ear off about this. In northeastern Ontario, in the context of satellite dialysis we actually have more capacity than we need, but we want to work as a second phase to examine how we can expand nocturnal. So the first phase is, we've got to build some additional capacity because we're running into real-time immediate constraints for patients in those five hot spots that I mentioned. The next step will be to look at how we can expand nocturnal, and the ministry is working very vigorously on that right now.

M^me^ France Gélinas: Okay. Any sorts of timelines for the first phase—the second phase being the one I'm most interested in. When will nocturnal dialysis be increased?

Hon. George Smitherman: The first phase is, I would say, practically immediately—like, very soon—and once we get that out the door, we will take advantage of looking to expand capacity in existing operating centres, some of which are independent health facility models. So there will be some RFPs that will be necessary. That's going to take us a little while. I think that analysis, that language that you used, is probably how the ministry has engaged the capacity that's out there in the system now, looking at what we can do to build on the nocturnal.

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I can't give you a timeline, but people are working on it as a major priority within the ministry. I would anticipate that in the span of the next year, we're going to see a lot of progress on taking advantage of nocturnal capacities. But I don't know how long it takes to build those programs up etc., so I'd be a little bit out on a limb to give any further detail about that.

M^me^ France Gélinas: Okay. Do we know how many people are receiving nocturnal dialysis in Ontario right now?

Hon. George Smitherman: Yes, I'm sure that we do. I don't have that information at hand. Some hospitals are funding it through their global budgets etc., as you're well aware of. It may take us a little bit of time to bring that information together, but yes, I'm sure we can provide it.

M^me^ France Gélinas: I would be curious to know if there is any northern resident who is receiving nocturnal dialysis.

Hon. George Smitherman: Well, we've heard of at least one. But yes, we'll get you more of that information.

M^me^ France Gélinas: Okay; sounds good. The next one is the announcement that slipped out, but it's out there now: It's the sex reassignment surgery. I don't know if you had intended to make the announcement on the day of the gathering, but anyway, you did. I understand that many in the transgendered community are very concerned that the guidelines to access sex reassignment surgery will be the same as when the surgery was delisted in 1998. Can the minister tell us how he plans to establish the new guidelines, who he's engaging to

ensure that the guidelines are reflective of the wishes of the trans community, and when he plans to publicly release those?

Hon. George Smitherman: It's a good question. Let me answer your question in this way:

(1) I have a lot of personal engagement with the trans community and I have a pretty good sense for the positions. But the first message that has been delivered has been positive. People say that maybe in some of the details they have concerns, but overall it has been quite positive to see that there's some opportunity for progress.

(2) I can't remember the specific name—I wish that I could—but there are kind of world standard guidelines that have been adopted broadly in the western world which will inform the work that is done. When we think about CAMH as an example: It's not like, down at CAMH, they'll make up their own mind about how to do this. There is a wide body of world literature which will be depended upon in helping to shape the appropriate way to make this program work.

(3) We have seen the emergence of a lot of capacity for the broad—trans individuals don't identify as gay people but as part of the very broad community. The Rainbow Health Network is something that we funded as a government at the Sherbourne Health Centre—I met with the leadership of the Sherbourne Health Centre yesterday—and they're going to be a partner in working in the development of this model. I will be writing to them and to CAMH within the next few days, beginning the process of shaping the way that a program can work.

Your final point was: When can we anticipate that? I don't have a date in mind, but I took a meeting on it yesterday. I've already looked at the draft of a letter today and anticipate sending that letter and getting the ball rolling quite soon. I'm quite confident that we're going to be able to work co-operatively, because the Rainbow Health Network and the Sherbourne Health Centre are in a really good place. They're very trusted organizations by the trans community and we're certainly going to be engaging them a lot. Susan Gapka, a constituent of mine—one example of a very proactive leader on this—is also a working member of the Rainbow Health Network. We're really looking to build off some of those capacities which have emerged.

M^me^ France Gélinas: Okay—

Hon. George Smitherman: Can I just say one other small thing?

M^me^ France Gélinas: Sure.

Hon. George Smitherman: We also think that there is an opportunity—I think one of the federal government research-granting bodies has initiated a research project into some of the underlying health issues for the trans community. We feel that we can gain a lot of insight as well from that research work, which is already ongoing. We're going to make sure that we're building that into our knowledge base.

M^me^ France Gélinas: I would just add a little advocacy: There is a trans community in northern Ontario. The agency that you've been talking about certainly have their headquarters and connect well with the people of Toronto, but there is a trans community outside of Toronto, and certainly in northern Ontario.

Hon. George Smitherman: I'm so aware of it and I'm glad that you've raised it, because yesterday I had this discussion in the context—I said, "What if we're talking about a trans individual from Dryden?" I don't know that there are, but it's quite likely or quite possible. We have to be building a model that works.

The Rainbow Health Network: The very notion there is that they would work to build referral capacity all across the province of Ontario. I actually recommended to them that they speak to you, because I think community health centres are one example of part of a kind of network that could emerge as an affirming environment for the broader LGBTTQ community.

I don't think it's going to be practical for us, because we are dealing within the grand scheme with a very small number of people, to create a hub-and-spoke model, but we do think that through the use of technology and building the network we can shrink some of the distances that exist and make sure the capacities that we have at the Sherbourne Health Centre emerge to lend support to the broader trans community across the province. This is what we're working towards. We have a lot of work to do.

M^me^ France Gélinas: And no fixed timeline?

Hon. George Smitherman: No, but the policy decisions and approvals have been taken, so we're working on it expeditiously. That's why you can see that I've been engaged in it even this week.

M^me^ France Gélinas: All right. I'm switching over to public health. We all know at this point that there are a lot of public health units that don't have a full-time, fully qualified medical officer of health. I was wondering if your ministry tracked the vacancies within the 36 health units at the level of leadership—certainly, a medical officer of health—but also at other levels within the organization.

Hon. George Smitherman: I do know that we track it at that highest level, but I don't know beyond that what statistics might be available. Do you have anything?

Mr. Ron Sapsford: I don't know for sure. I would doubt that we track below the level, but certainly we keep track of vacancies in the medical positions, yes.

M^me^ France Gélinas: And is this something that you can share with us on a—do you track them twice a year or once a month or—

Hon. George Smitherman: I think the number is what it is, and as it moves we know what it is on a real-time basis, because somehow or other, the Ministry of Health is signing letters which confirms those things.

Did you also raise the matter of compensation in your question?

M^me^ France Gélinas: No, but go ahead.

Hon. George Smitherman: Because again, I'm into the situation where some of this is a matter of discussion in the context of the OMA negotiations, but last Monday I did speak to the ALPHA group, the Association of

Local Public Health Agencies. I did give them an undertaking that we were working on the matter of compensation as a priority.

We've also increased our capacity to train individuals to take on those roles, but I have to acknowledge that we've not been as successful in that area as we need to be. I think that the other thing, which is identifying the elephant in the room, is that there is pending advice to the government with respect to possible amalgamations of health units. We haven't, as a government—the ministry has worked on this, not to the point that they've offered advice to the government and not to the point that the government has considered this as a matter, but that's also something that's kind of hanging in the balance and part of the overall conversation. It seems that some health units, which are quite small, don't have the critical mass which allows them to engage that highest-level resource of an MOH.

Mr. Ron Sapsford: As of June 1 this year, 13 of the 36 public health units have acting medical officers, so that would be the measure of the vacancy rate.

M^me^ France Gélinas: Over 30%. I know it was one of the recommendations from the SARS report, so it has been tracked, so we see—but it was the same back then. It was 13.

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Hon. George Smitherman: And it has been lower. That's actually as high as the number has been in a little while, because we just had one or two retirements. The numbers do bounce around a little bit, but mostly it has been to just slightly one side or the other of 10.

M^me^ France Gélinas: I know that you have talked about the status of the 10-year health system plan developed by the ministry, and you've explained to this committee that it has been delayed. I'm curious to see: Is the government putting any resources into developing a similar 10-year plan, a healthy Ontario strategy plan, a strategy to improve population health?

Hon. George Smitherman: I don't know whether there's such a plan in place, but that's a question more appropriately put to the Minister of Health Promotion.

M^me^ France Gélinas: Of health promotion. Okay. I'll come back to the health units, then. A new public health unit program standard and the protocols and performance management frameworks are due to be released this summer, for implementation in 2009. Is the development of these program standards on schedule, and what resources will be provided to the health units to meet these standards? What resources will be allocated to ensure that the province can adequately monitor the implementation? Where would I find this in my trusty little book of estimates?

Hon. George Smitherman: I can only vaguely answer one small part of that, and that will give us a chance for the deputy to flip some pages and give you some more information. On the resourcing issue: In the last four or five years, if we look at the public health funding, it has practically doubled. I've been very clear, as I did when I was at the ALPHA meeting, in saying that if we look at the trajectory of public health spending, we've been operating pretty much in a 5% world, and I don't see anything on the horizon that's going to make it possible to see substantial enhancement beyond that. That's a high-level answer, but I really think that those are going to be the parameters in which we're operating. The deputy may want to—whether it's on point or not, you could decide, but there has been some pressure from public health to take into consideration, in that annualized funding, growth in high-growth areas, and also taking a harder look at the underlying circumstance of poverty, as an example, because those are obviously important influences in the kinds of needs that a public health unit would be seeking to address in a particular community.

Mr. Ron Sapsford: On page 101 is the vote where you'll find the details about public health expenditure. The question about how much is allocated specifically to implement the review is not identified here separately, but I'll point to the lines where the provisions would be. The $98,196,000 is the total increment for 2008-09 over the previous estimate, and if you go up to "Official local health agencies," the $56 million would be the bulk of the transfer. That would be for increments to public health expenditure. It's also an increment related to cost-sharing, and this is, I believe, the final year. "Outbreaks of disease" and "Tuberculosis prevention" would be the other two components.

Specifically in the amount of growth related to mandatory programs: Our estimate is about $7.8 million. The original review of mandatory programs, though, was not from an expansion point of view; it was simply to review the core programs, to look at what criteria were in place for program service delivery, to clarify those aspects of it. It was never undertaken with the notion that there would be large resource increases in order to complete the review. But in some cases there will be adjustments, and it's covered off in this estimate, within those three amounts.

M^me^ France Gélinas: But are we still on target for—

Mr. Ron Sapsford: Yes. And the review—

M^me^ France Gélinas: When?

Mr. Ron Sapsford: It should be, I would suspect, within the next couple of months. We've done the review and the consultations, and the final documentation is being prepared, and then we'll go on to the approval of the government and then out for implementation.

Hon. George Smitherman: I'm out of here.

The Chair (Mr. Tim Hudak): Do you want to recess, or do you want to have questions to the deputy minister? You have about just over a minute in your time.

M^me^ France Gélinas: I have a minute left in my time?

The Chair (Mr. Tim Hudak): You do have another 10 minutes after this.

M^me^ France Gélinas: Okay. And they don't get 10 minutes? It goes back to—

The Chair (Mr. Tim Hudak): That's right.

M^me^ France Gélinas: No, my next question is not a one-minute question.

The Chair (Mr. Tim Hudak): Why don't I add on your time to your next rotation?

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

The Chair (Mr. Tim Hudak): Under our agreement here, we now go to the official opposition. Ms. Witmer, do you want us to recess temporarily until the minister returns, or do you have questions for the deputy that you'd like to ask first?

Mrs. Elizabeth Witmer: No, I can continue with the deputy.

I'm just going to take a look at the chronic disease file. As you know, the Ontario Health Quality Council recently, in their 2008 report, said that only 35% of Ontarians with coronary artery disease were considered for each of the three possible medications: Aspirin, beta blockers and cholesterol-reducing drugs. These are drugs that are recommended by experts. The quality council has suggested that Ontario could avoid more than 1,200 cardiac bypasses and balloon angioplasties by administering these drugs. I would say to you, Deputy: Are there plans that would allow all Ontarians to have the opportunity to have access to those three approved drugs in the future?

Mr. Ron Sapsford: As an insured benefit?

Mrs. Elizabeth Witmer: Yes.

Mr. Ron Sapsford: The vast majority of Ontarians have access to these drugs either through existing programs—the Ministry of Ontario drug benefit—or through their own drug coverage plans, where they exist through employers. I think the point you raise about a more aggressive approach to chronic disease management is an important point. In the government's agenda over the course of the next three years, focusing more on better clinical tools, on better processes for the system to use to better manage chronic diseases, is very much part of the ministry's agenda. As the minister said previously, the initial focus is on diabetes and the management of it, to be followed closely by asthma and congestive heart failure, as you've mentioned.

The approach the ministry is using in planning for chronic disease management is across a number of diseases: again, identifying what is best practice; making sure that the clinical delivery system is aware of that; and providing the tools that the system needs to manage patients better between primary practice, community practice and institutional management. The underpinning of that, of course, is the electronic health system. So the observations you've made from that report are consistent with what we're trying to do over the longer term.

Mrs. Elizabeth Witmer: In your budget you did set aside $190 million over three years to implement a chronic disease prevention and management strategy, and we know that it's going to start with diabetes. But we took a look if we could find this disease prevention strategy online, and we couldn't. Do you have a copy of the strategy?

Hon. George Smitherman: Yes. I mentioned in my earlier answer with respect to that strategy and eHealth that they're aligned. They still have some elements of cabinet-level approvals, so I think it will be just a little bit down the road before you see a substantive announcement and dissemination of more of that information—not too long, but a little bit down the road yet.

Mrs. Elizabeth Witmer: Okay.

I'd like to turn to nursing. Can you explain why the new-graduate initiative was replaced by the nursing graduate guarantee?

Hon. George Smitherman: Why one was replaced with the other? I don't understand the nature of the question. The new-graduate guarantee we implemented last year?

Mrs. Elizabeth Witmer: Right. Does that replace the new-graduate initiative?

Hon. George Smitherman: Maybe in a renaming, but it was a program that was—we piloted a program, and it was quite short in the amount of time. The feedback was, "That's nice, but it doesn't really address that gap in the clinical awareness that the graduating nurse had." So the new-graduate guarantee was informed by the initiative but dramatically expanded—more than doubled—in the amount of time that it paid for. That's obviously now firmly embedded in our ministry's budget as a base program. Now we're just at the starting point of the second year of it, but we're hopeful that it will produce results that are as good as the first time around, where 86% of nurses who participated acquired full-time employment.

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Mrs. Elizabeth Witmer: If we take a look at the College of Nurses numbers, we see that the number of people leaving the profession is greater than those entering it. I just wondered what plan you have to deal with what obviously is an issue of concern when we already have a nursing shortage.

Hon. George Smitherman: I don't think that's the full story of what the College of Nurses numbers tell us. The data that's available on page 2 of that booklet that we handed out earlier—from 2004 to 2007—showed a fairly substantial growth of nearly 7,000 practising nurses in Ontario. But obviously we know that there has been aging that has occurred in the nursing workforce, and that's why initiatives like the late career nursing initiative, which really does use those nurses as mentors and preceptors and engages them in other roles to enhance their ability to transfer skills and learning to the young nurses—that's why we've made progress on those points. This is going to be the challenge on an ongoing basis, obviously: that there can be predictions or projections of nurses who are able to leave, and we're working as hard as we can to encourage them to stay.

One small point on this—I think you'll be aware of it—maybe I mentioned this last week. At the end of the 2007-08 fiscal year, the nurses were in negotiation with the Ontario Hospital Association—ONA and OHA—and we offered to the OHA the capacity to offer their nurses what I would call a loyalty bonus, and it was weighted, if you will, towards acknowledging the long-standing service of Ontario's nurses. That agreement had the

highest level of ratification of any agreement in the history of the ONA-OHA relationship. We hope that's a good omen, but we have lots and lots of work to do to address all the concerns that might exist about nursing on the front line.

Mrs. Elizabeth Witmer: The 2008 budget announced $107 million over three years for 2,500 personal support workers and approximately $110 million over four years to hire 2,000 nurses. That's in addition to the annualization of last year's $14-million announcement of 1,200 RPNs. My question to you is: What are the estimated amounts for these three categories for this fiscal year and the next one—2008-09?

Hon. George Smitherman: Can you just clarify the "three categories" part?

Mrs. Elizabeth Witmer: It's $107 million over three years for 2,500 PSWs and $110 million over four years for 2,000 nurses, and this is in addition to the annualization of last year's $14 million of the 1,200 RPNs.

Hon. George Smitherman: What I can tell the honourable member for—I think that, actually, most of this information is already on the record from earlier questions in estimates. On the PSWs, we're going to implement 865 of those this year—is that August 1 or November 1? I've got a mental block.

Interjection.

Hon. George Smitherman: August 1. The funding for the PSWs kicks in on August 1, with 865. The allocation on the 2,000 nurses is yet to be confirmed. The 1,200 RPNs, although I have to acknowledge that it has not been our smoothest launch of new resources to date, is ongoing. That's kind of in process at present. The reason that the RPNs required a full year is because it had been initiated in the fiscal year in 2007-08. Now it's a full-year implication.

Mrs. Elizabeth Witmer: If we take a look at the human resource cost, is the ministry going to flow through the RN signing bonus into 2008-09, and if so, how much are you allocating in the estimates?

Hon. George Smitherman: It was one-time, and it was already paid for from the 2007-08 finances.

Mrs. Elizabeth Witmer: Okay—

The Chair (Mr. Tim Hudak): That is going to conclude your time, Ms. Witmer.

Your last round now to the third party. You have an additional one minute from previously; you have 11 minutes.

M^me^ France Gélinas: I will continue on the nurses before I come back to my question. In the fact sheet that you circulated, you show that 86% of the Ontario nursing graduate guarantee program ended up finding full-time employment. Could you tell us where those figures come from?

Hon. George Smitherman: The figures come from the analysis of the nursing secretariat. They're our own figures. Who else would have them?

M^me^ France Gélinas: I'm wondering.

Hon. George Smitherman: The individuals register, through HealthForceOntario, for the program, and that gives us the capacity to track that information.

M^me^ France Gélinas: I can tell you that at the Sudbury Regional Hospital it's a program that is very well loved, and the nurses who participated have nothing but good things—in the units that they're on—to say about it. But they're very surprised with the 86%, because in Sudbury, I think the uptake of full-time employment was only 17%, not because the jobs weren't there but because the nurses decided to continue to be part-time for reasons of their own. We were really surprised when we saw this. Somebody must have been very high, because certainly Sudbury Regional was very low.

Hon. George Smitherman: Maybe that's a comment on the way that Sudbury Regional worked the program, and maybe we need to put more pressure on them to achieve more success overall. There was a strong differential, too, between RNs and RPNs. Even though RPNs did better, they still continued to struggle in achieving full-time employment.

We'll get HealthForceOntario—Dr. Tepper is not with us this afternoon, but we'll definitely get back to you and tell you what we can. We'll seek to confirm that Sudbury Regional actually stands out like an anomaly. I'm familiar with Sick Kids. Sick Kids has integrated 200 new nurses into their program. The University Health Network and St. Mike's—these are close to home for me—all had very big numbers and high levels of achievement. Sometimes it relates to the amount of turnover that occurs in the hospital itself, because these hospitals are close by to so many others. Perhaps in more densely populated areas, with more hospital corporations, there's more attrition and turnover, which maybe provides more opportunities. We'll try and tease out more information about the performance of the program at Sudbury Regional.

M^me^ France Gélinas: I don't want to leave the wrong impression. There were full-time jobs available for those nurses. They made choices not to take them for personal reasons, not because it wasn't offered, which is why I'm thinking: How come so different than the rest of the province?

Hon. George Smitherman: It's an issue that comes up all the time, because the Registered Nurses' Association of Ontario—Doris Grinspun—pushes very vigorously on 70% full-time nursing, which we accept as a target. But then I heard very directly from some part-time nurses in Thunder Bay who were very satisfied—even though they were impacting statistics, they liked things as they were. When we put too much pressure on the full-time, it was starting to rattle the stable opportunity that they thought they were working within. So it's a good lesson.

M^me^ France Gélinas: That was just in follow-up to hers; I'll come to back to my question on public health. Will the government require all public health to include advocacy and intervention to improvements in the determinants of health as core public health work?

Hon. George Smitherman: I'd have to say either no or—Dr. Williams is here; he might be able to assist us on this point. Deputy, was that a part of the work of the mandatory program review etc.? I'm not certain, but I don't believe we've been contemplating it at this point.

Mr. Ron Sapsford: I stand to be corrected, but the core program review dealt with very specific areas of public health service like maternal and child health, immunization and school health programs, as opposed to issues around the determinants of health. But I can clarify that.

1650

M^me^ France Gélinas: Okay, thank you. My next question is, again with public health, when will the Ontario Agency for Health Protection and Promotion be fully up and running? Are we working on a strategic plan or anything like that?

Hon. George Smitherman: Fully up and running might be a definition in the eye of—different people might characterize that. But I can tell you that substantial progress is being made. On July 1, Dr. Vivek Goel, a very accomplished gentleman whom they've hired from—he was provost at the University of Toronto; he is coming in as the chief executive officer of that body. There has been a board functioning for quite some time. We're also looking at making progress on acquisition of appropriate real estate.

Just for a matter of public record, we're going to make sure that their offices, which we anticipate would be located at MaRS, will bear the name of Dr. Sheela Basrur, as an important acknowledgement of all that she's done and also an important connection back to SARS, which is part of the rationale for the coming to life of that agency in the first place.

They're making good strides.

M^me^ France Gélinas: So will that agency do the full breadth of public health practice, not only infectious disease?

Mr. Ron Sapsford: The detailed discussion with the agency is going on now. We're right in the midst of negotiating the memorandum of understanding, which is required as a crown agency. That work should be finished over the course of the summer. The first major operational responsibility they will take on is the operation of Ontario's public health labs system. We're targeting that transfer for this fall, so before the end of this calendar year. That will be their first major responsibility. The rest of their mandate is in the area of public health research, and then specialized support to the ministry and health units on things like epidemiology and immunization strategy or policy.

So the agency itself will not deliver public health services directly to the public other than what I've said about the public health laboratory service program. Their major function is in support to the Ministry of Health's public health division as well as directly to public health units for that specialized public health backup.

M^me^ France Gélinas: So the answer to my question is, it's not only on infectious disease, but it could be the full breadth of—

Mr. Ron Sapsford: Yes, other areas. Part of the discussion between the agency and the ministry right now is on these points, in terms of the scope and the kind of involvement that they will have over the course of the next year and beyond.

M^me^ France Gélinas: I'm conscious of the time. How long, Chair?

The Chair (Mr. Tim Hudak): I'm just checking. Just under four minutes.

M^me^ France Gélinas: Okay, I have one quick one, if it can be done, because I have two left that I'd like to get in. I understand that a Leisureworld long-term-care facility, where the Ministry of Health recently put a halt on new residents, had a higher rate of infractions. According to an FOI obtained by CBC, this Leisureworld had eight infractions, on average, rather than five. However, at the same time, the ministry approved the transfer of six Diversicare homes to Leisureworld. Can the ministry clarify why that was done?

Mr. Ron Sapsford: The time frames are important here. The transfer of the homes was at the beginning of 2008, and some of the other information you've quoted was subsequent to that, in April and May, I believe. The ministry is currently monitoring two of the homes quite carefully—one earlier this year, where there was a more intense monitoring of the home. The object of ministry inspection is to bring the home into compliance. In the first case, the home was brought back into compliance with ministry standards. With the second Leisureworld home, we've received their compliance report, and the ministry is conducting its review that the response to the investigation and the inspection report is adequate. We'll continue to monitor that home closely until such time as the plan is implemented, which I suspect will be very shortly.

M^me^ France Gélinas: Can I have a breakdown of infractions just by not-for-profit versus for-profit long-term-care homes?

Mr. Ron Sapsford: I don't know, but I will find out. I suspect the answer is yes. It's a question of sorting out which is which and reporting the numbers.

Hon. George Smitherman: Some of that can probably be found on the public reporting website as well.

M^me^ France Gélinas: Okay. I know my time is coming to an end.

The Chair (Mr. Tim Hudak): Last question.

M^me^ France Gélinas: I had the opportunity to attend the launch of the Sharkey report, which you know is a report that I had been waiting for for a long time. In the House on May 7, I asked you if you had received the report and you said no, you hadn't received it. I can quote you, "I have not received the report but would want members of the House to know that upon receipt of the report, it will be in the public domain and made available for all of us to benefit from it." Today, Mrs. Sharkey

seems to have said that she gave you the report in mid-May and you made it public today.

Hon. George Smitherman: You just said that she gave me the report. I think that now we're into nuance a little bit. It's very possible that the report had been in the ministry for a while before I saw it, and there's no doubt that it took us a little while to synchronize our dates and find an appropriate opportunity to put it into the public domain. I still haven't read the report, but I was briefed on its contents when I met with her about 10 days ago or so. So my timelines for instant release are certainly not quite as instant as I had alluded to, but the May 15 date—she was kind of bouncing around on the dates, but I think that might have related to her contact with the ministry and briefing that she provided to them around some of the contents of the report.

The Chair (Mr. Tim Hudak): Okay. That does conclude the time of the third party. Madam Gélinas, thank you very much. The government members have 10 minutes to wrap up. Mr. Rinaldi.

Mr. Lou Rinaldi: Well, thank you, Chair, and how time flies. I'm just going to make a couple of statements and allow the minister, if he has any closing remarks that he wishes—so I don't have a specific question except to thank the minister, the ministry staff and the minister's staff for being so attentive and providing us with all the information, and all the committee members from all sides. It's been a few hours with this particular ministry, but I know that I learned an awful lot even though I'm from the government side, when we drill down to the details—and to you, Chair and the legislative staff for your commitment and timing. We know that this will probably be our last—well, it is, I guess, before we recess. So everybody have a safe summer.

Minister, it's up to you—

Hon. George Smitherman: Well, I don't often find myself in the position of feeling talked-out, but a combination of weekend activities in Ottawa and a serious summer cold seem to have got me in that spot. But I really do want to thank Ms. Witmer, who very appropriately acknowledged—she knows that a $40-billion budget is a lot of detail. There are a lot of numbers and the amount of preparation that goes into bringing a ministry forward is really quite extraordinary. So I want to just echo the nice words that were on offer from members of the committee.

The Ministry of Health has got thousands of very dedicated folks. I've been privileged to serve alongside them and to have this opportunity to thank them for all the work they've done. We have some here and some who are in a committee room down the hall. I know they always wish that they could get called forward to answer more of the questions, but the deputy and I enjoy the chance to engage with members of the committee and to thank you for all the questions that have been raised.

We've got lots of work to do to get back to members about specific questions that they've raised, and we'll be attentive to doing that just as quickly as we possibly can.

I just want to thank you, Mr. Chair, for having us before the committee. I hope that you'll consider supporting our ministry's estimates.

The Chair (Mr. Tim Hudak): I don't know if it's going to come to a vote by the Chair to break a tie here. I'm not so sure. We'll do the votes momentarily.

Again to you, Minister, Deputy Minister and all of the senior staff from the Ministry of Health and Long-Term Care, thank you for dedicating approximately 10 hours of your time to the committee. I do appreciate your good endeavours to get the responses back to members and appreciate the minister's and deputy's approach on being so open to the questions of the members of the committee.

We will now proceed to the actual votes for the estimates of the Ministry of Health and Long-Term Care.

Shall vote 1401 carry? Carried.

Shall vote 1402 carry? Carried.

Shall vote 1403 carry? Carried.

Again, unless we ask for a division, these are just verbal votes.

Shall vote 1405 carry? Carried.

Shall vote 1406 carry? Carried.

Shall vote 1411 carry? Carried.

Shall vote 1412 carry? Carried.

Shall the estimates of the Ministry of Health and Long-Term Care carry? Carried.

Shall I report the estimates of the Ministry of Health and Long-Term Care to the House? Carried.

That concludes our votes. I will report that to the House timely.

A couple of quick housekeeping items. Mr. Chudleigh recently wrote to the clerk asking for responses from the Ministry of Economic Development and Trade. The clerk did follow up with the ministry and the ministry is endeavouring to get the answers back to Mr. Chudleigh and committee in due course, and the clerk will respond to Mr. Chudleigh accordingly.

Similarly, we've had a signal from the Ministry of Aboriginal Affairs that their responses should be available hopefully within a week or two.

In consultation with the members as well, we will not be sitting for our regular meeting of estimates tomorrow. We thought that if we have the Ministry of Northern Development and Mines, which is our next group, it's best to just have it as a block for when we come back together in September, as opposed to dividing it up between June and September. So we will not meet for our regular meeting tomorrow.

Folks, thank you. This was an outstanding review of the estimates of health. I thought there was a very solid tone here at committee, a very intelligent series of questions. I thank you for that. Thank you to the clerk and the research official and Hansard.

Folks, we are now adjourned. Have a great summer.

The committee adjourned at 1700.

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