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Tuesday 27 October 2009

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Mardi 27 octobre 2009

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: Garfield Dunlop
Clerk pro tem: William Short

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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON ESTIMATES

COMITÉ PERMANENT DES BUDGETS DES DÉPENSES

Tuesday 27 October 2009

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The committee met at 0901 in room 151.

MINISTRY OF HEALTH AND LONG-TERM CARE

The Chair (Mr. Garfield Dunlop): Good morning, everyone. I'd like to welcome Minister Matthews and everyone from the Ministry of Health and Long-Term Care. We're here today for the consideration of estimates of the Ministry of Health and Long-Term Care, and we're here for a total of seven and a half hours.

The ministry is required to monitor the proceedings for any questions or issues that the ministry undertakes to address. I trust that the deputy minister has made arrangements to have the hearings closely monitored with respect to questions raised so that the ministry can respond accordingly. If you wish, you may, at the end of your appearance, verify the questions and issues being tracked by the research officers.

I did want to point out today that we had asked around, and I know that Arlene King, the chief medical officer of health from the public health division, can only be here today, having a lot to do with H1N1 and the distribution of the medicine. If anybody had any questions today that might be specific to that, it would be helpful, because Dr. King will be here just today. Are there any questions before we start?

I will now call vote 1401. We will begin with a statement of not more than 30 minutes by the minister, followed by statements of up to 30 minutes by the official opposition and the third party. Then the minister will have up to 30 minutes for a reply. The remaining time will be apportioned equally among the three parties.

What will likely happen here today is that we will recess at 10:20, and at that time, member for the third party, you'll have another 10 minutes to begin when we reconvene in the afternoon.

With that, I'd like to welcome the minister. Minister, you have 30 minutes for your opening statement.

Hon. Deborah Matthews: Thank you. Mr. Chair, committee members from all parties and members of the public, it is indeed a privilege for me to have this opportunity to appear before the Standing Committee on Estimates.

I'd like to start by thanking the members of the committee. I know you put a lot of time, energy and thought into this process, and I do want to thank you for that.

I've been in this job for just one day short of three weeks, but I have been a member of this Legislature since 2003. As all of you will know as MPPs, you become very familiar with some of the challenges in the health care sector through your work as an MPP. I can tell you that I am very proud of what our government has accomplished in the time that we have been in government.

The investments that we've made into Ontario's health care system have paid off for patients across the province, investments that include an overall increase of 45% in health care spending in the last six years. We have doubled the funding of public health programs, we now spend more on mental health than has ever before been spent and we've increased hospital funding by $4.6 billion. That's an increase of 42%.

However, I don't measure success by how much money we spend; I measure success by how well we have done by the people of Ontario. We have done more than simply funnel money into the system; we have enhanced care for patients.

Through the hard work and collaboration, of course, with health care providers, our government has seen improvements to the delivery of health care services that better meet the needs of patients, that implement best practices of care across the province and—I'll be speaking more about this later—we have begun to publicly report on how well we are achieving the goals that we have set for ourselves and for our system. What we have accomplished has truly improved the health care that Ontarians look to each and every day.

As I said, this is my third week on the job as Minister of Health, a position I am honoured to have received. I am excited to become a part of the progress made in the health care portfolio going forward.

I'd like to begin my remarks by giving you all a snapshot of a day in the life of Ontario's health care system. Today, about 160,000 of us will visit a family physician—perhaps more, given the H1N1 pandemic. Today, around 41,000 X-rays and 2,000 other diagnostic imaging tests will be done and 50 of us will have hips or knees replaced. This is no small feat. These are just a few examples of what happens in our health care system on a day-to-day basis.

From the beginning of our government's mandate we recognized that the issues facing the province's health care system are complex and we appreciated the difficulty surrounding the system's sustainability, so we've

changed the way health care is provided to the province to better meet the needs of Ontarians. For instance, to ensure that health care reflects the local needs—and this is such a diverse province—we have created the local health integration networks to plan, to fund and to integrate health care services in each area of the province.

Added to our longer-term challenges are the recent global economic downturn and its ongoing effect on the province's revenues. In both the 2008 and 2009 fall economic statements, the Minister of Finance made it clear that the global economic downturn would not leave Ontario unscathed. Our government has indicated that we will stand by our commitments, but the implementation of some programs will take longer to achieve than had been anticipated.

Despite the challenges posed, we are absolutely determined to have a system that is patient-centred, transparent, accountable and sustainable, a system that provides the highest quality of health care in the world.

To achieve its goals, our government will continue to focus on three major priority areas: We're reducing wait times—our current focus is a special emphasis on emergency department wait times; we're improving access to family health care for all Ontarians; and last, but certainly not least, we're making sure that every dollar that is spent on health care is invested wisely and prudently and improves health care for Ontarians.

0910

We chose these three priorities because we know they are important to Ontarians and we're working toward these goals with the patients' needs at the top of our list. I believe that by addressing these issues, we're not only promoting patient satisfaction and enhancing the confidence that Ontarians have in the health care system, we're providing patients with the highest level of care possible.

We started by listening to what Ontarians wanted us to do most. Ontarians asked us to reduce wait times for health care services, for surgeries, for transfer to an inpatient bed when hospital admission is necessary and, of course, Ontarians want a reduction in time spent in hospital emergency rooms.

The emergency room has always been and is still a default doorway of sorts into the health care system. People go to the ER when they don't know where else to go. Ontarians make more than five million visits to ERs every year and approximately half of those visits are by patients who require care that does not necessarily come from the emergency room departments. Therefore, our government is focusing on two components to improve ER wait times. We need to reduce the number of people who turn first to the emergency room for help, and when people do come to the emergency room we need to get them treated and out of the ER either into admission, into the community or into some kind of alternative level of care place more quickly.

The wait time issue quite simply cannot be solved by focusing on the ERs alone. It reflects a broader system imbalance that goes well beyond the waiting room. To achieve this goal, last spring our government launched the emergency room/alternate-level-of-care, or the ER/ALC, strategy that encompasses the following coordinated steps: Removing ER demand by providing people with appropriate care and options outside the ER so they can avoid the ER in the first place; the second step is building ER capacity and processes so that patients can get the fast, high-quality care they deserve when they truly need it; and the third step is faster discharge for patients requiring alternate levels of care, moving them out of acute care beds and into a more suitable care setting.

The Ontario Hospital Association reports that 18% of acute care beds in Ontario's hospitals are occupied by patients who are waiting for post-acute services, community supports to go home or to move to a long-term-care facility—18% of the acute care beds are being occupied by people who don't need that level of care. These beds are then not available to acute care patients who may be waiting in the emergency room to be admitted to the hospital.

Our government's alternative-level-of-care, or ALC, strategy is aimed at getting this group of patients out of the acute care beds in a timely manner and into settings that better suit their specific health needs. Our unprecedented investment in a $1.1-billion aging-at-home strategy works to improve access to community-based health services to encourage independence for the elderly in the province. Services such as supportive housing, home care, community care services like meal delivery and transportation to appointments, specialty geriatric services, and health and wellness programs work to reduce demand on hospitals and the need for long-term-care home admissions, they improve the level of care that seniors receive and they increase the health care services available to seniors.

At the end of the day, the only way to know how well all these strategies are working is to measure the results, because if you can measure it you can improve it. That's why we began public reporting of ER wait times in February of this year. Ontarians can go online to ontariowaittimes.com to access information about their local ER whenever they need to. The most recent data show provincial ER length of stay decreased to 8.9 hours from the April 2008 baseline of 9.4 hours—so we're making progress; we're moving in the right direction.

We're also getting closer to meeting our four-hour target for patients with minor uncomplicated cases. Currently, nine out of 10 such patients spend no more than 4.8 hours in the ER from the time they register to the time their visit is complete and they leave the ER. Our target is four hours. The ER length-of-stay targets were established to ensure Ontarians are receiving the highest quality of care possible and in a timely manner. The success we've seen in reducing ER wait times will strengthen the health care system and increase public satisfaction. I'm sure you will all agree with me that waiting in an emergency room waiting room is not where you want to be spending your time. We would all rather be back at home.

Our second priority area is improving access to family health care for all Ontarians so that patients have a professional to turn to to help them navigate through the health care system, so that they can access clinical services closer to home, so that they will experience a better continuity of care and so that they have alternatives to hospital ERs for non-emergency health care.

Over the past four years, we've made significant strides in increasing Ontario's health human resources. We have more family health teams. We have more community health centres. We have more doctors and more nurses working the front lines to provide care to Ontarians.

However, we still have work to do. There are still Ontarians seeking a family health care provider, particularly Ontarians in disadvantaged populations and those with special health care needs. That's why we've committed to adding 50 new family health teams to the 150 that we have already created; we're establishing 25 new nurse-practitioner-led clinics—the first one in Sudbury; and we're increasing physician supply, the number of physicians, including 100 new medical training positions in the province.

Family health teams and nurse-practitioner-led clinics are particularly successful models. They're currently serving more than two million Ontarians; two million of the 13 million people in the province are being served through family health teams or nurse-practitioner-led clinics. Of those two million, 300,000 previously did not have a family doctor. By providing comprehensive and collaborative care closer to home, they are reducing the need for ER visits, and they're easing the strain on hospitals by enabling them to deliver the acute care they were designed to deliver and deliver it faster.

We've built and are continuing to build different access points in health care, from family health teams to nurse-practitioner-led clinics, from community health centres to urgent care centres, all to alleviate pressure on our hospitals. To ensure that patients are using these ER alternatives, our government has launched two interactive tools for patients. We did this last February.

The Your Health Care Options website, with Google-style mapping, provides Ontarians with information on health care options in and around their communities. Health Care Connect is Ontario's unattached patient registry. It's accessible over the phone and online, and it helps people without a family health provider find one. To date, over 11,000 Ontarians have been referred to a family health care provider through Health Care Connect, thousands of them being vulnerable individuals and those with complex medical conditions.

Together, our efforts have resulted in 800,000 more Ontarians with access to family health care since we came to power in 2003; 800,000 more Ontarians have access to a family health provider today than six years ago.

We've invested in the expansion of our health care resources and we're committed to promoting interprofessional collaboration to improve health care delivery. Our HealthForceOntario strategy is working to ensure that Ontario has the right number and the right mix of appropriately educated health care practitioners in the right place at the right time with the right skills. That means allowing regulated health professionals to better utilize their skills within their individual scopes of practice, a strategy that supports team-based care and interprofessional collaboration.

0920

Evidence shows that the benefits of this kind of approach are undeniable. They include better patient outcomes; improved access to care; increased caregiver satisfaction, which decreases turnover; and lastly, a more effective use of our precious health care resources. Our proposed legislation, Bill 179, would increase access to care for Ontarians and enhance a regulatory system that would increase patient safety.

I believe in the importance of building a health care system that is more efficient and easily adaptable to the changing health care needs of Ontarians. By encouraging a more collaborative health care system, we're improving the care that patients receive.

So far, I think you have seen that it takes more than one approach to solve the issues surrounding wait times and access to care. There is no one solution. All the investments we have made are working together to bring us closer to our goals.

Just as we look to a range of health care options to provide the right care in the right place, we're also looking towards several initiatives to support the changes we need to improve the quality of care patients receive. At the very centre of the support that we need to improve our system are the nurses, the doctors, the pharmacists and all the health professionals who have the health care of Ontarians put into their hands every day.

There are about 2,300 more doctors practising in Ontario today compared to 2003. Last year, we completed a 23% expansion of medical school capacity and we're working to add 100 more first-year medical school spaces.

We've also seen terrific success come out of the Northern Ontario School of Medicine. With 56 first-year spaces and with campuses in both Sudbury and Thunder Bay, the Northern Ontario School of Medicine is now training 224 medical students in the north, doctors who are much more likely to stay in the north, practise in the north and give back to the communities that have taught them what they know.

Ontario is also one of the few jurisdictions in the world to guarantee a full-time job opportunity for every new nursing graduate. Through the nursing graduate guarantee program, more than 7,700 graduates have been matched to a guaranteed job opportunity and 76% of new nursing graduates completing the program are transitioning into full-time employment. Without the dedicated support of our doctors and nurses, Ontarians would not be able to receive the level of care they do today.

The kind of care that Ontarians need is evolving, and we're working hard to improve the system to meet the

needs of patients today and tomorrow. Our investments in electronic health records are significant, and what we're working to create will undoubtedly improve our health care system. Electronic health records will ultimately result in better patient care and a more efficient health care service delivery for health care providers.

But as I stated earlier, we must ensure the greatest value for taxpayer dollars spent. Ontarians expect to see their tax dollars spent on high-quality health care policies and services, and so do I. Our government remains committed to ensuring that the money we spend on eHealth is devoted to initiatives that will strengthen and modernize the province's health care system.

We've taken the concerns brought forward in the Auditor General's special report on eHealth very seriously, addressing each of the recommendations in the AG's report, which are now well on the way to being fully implemented. We've established solid new rules and regulations that will ensure proper governance and accountability when it comes to procurements and spending. We've also reduced the use of consultants. Consultants are now used only when necessary. All tenders are open and competitive and we're cracking down on inappropriate spending. For example, if you were to look at the ministry's eHealth programs branch when it was transferred to the agency in April of this year, there were about 600 employees and 385 consultants. By the end of this fiscal year, the number of consultants will be 160. This is an overall reduction of 225 consultants, or 58%. The lessons we have learned through eHealth Ontario and this AG's investigation have helped us to improve procurement and expense policies right across government. We're setting a higher standard for everyone, inside the Ontario public service and outside, with broader public sector partners, by demanding more transparency, more scrutiny, more responsibility and more accountability.

Right now, I am focusing on moving eHealth forward. I believe that we're on the right path to achieve an electronic health record for everyone in the province, and investments made through eHealth to date are extremely valuable. We've made significant accomplishments. Currently, there are about 80,000 Ontarians enrolled in a pilot project for ePrescribing, which will reduce medication errors caused by paper prescriptions and will save lives. More than one million Ontario children already have an electronic health record through a network called eCHN, and four million Ontarians have an electronic medical record through a partnership with OMA called OntarioMD, which has signed up 3,300 physicians to date with plans to add another 5,700. EHealth has also helped to build the Ontario Telemedicine Network, one of the largest networks of telemedicine sites in the world. It connects over 50,000 patients a year to a doctor and has made Ontario a leader in the field of telemedicine. EHealth has ensured that every hospital in the province has gone filmless. It is now storing and using digital diagnostic scans.

It's important to remember what we have done up to this point. We have laid the foundation for the expanded services that eHealth will provide. We've built the highway on which these services will travel and we are continuing to develop the building blocks that will make EHR a reality. We know that there is still work to be done to get these tools into the hands of Ontarians, but what we've done has put us on the path to achieving our goal of an EHR, one of the most important investments our government can make for the future of our health care system. Let me state again that the reforms we've introduced have one, and only one, purpose: to better serve the people of this province with access to the highest quality health care.

When reviewing what we've achieved, I believe that you will agree that we're making big strides toward improving Ontario's health care system in a way that truly benefits patients. This government has worked hard to remove barriers and ensure better access to health services for all Ontarians by increasing access to the collaborative health care model, by reducing wait times in ERs for important surgeries and procedures and increasing the number of primary health providers. In the months and years ahead I will remain devoted to continuing the efforts that were passed on to me and I am confident that we will continue to make progress. Thank you very much.

The Chair (Mr. Garfield Dunlop): Thank you very much, Minister. You have about another five minutes that you can use. Is there anything else you want to add to what you've said there?

Hon. Deborah Matthews: I think we can carry on. I'm fine.

The Chair (Mr. Garfield Dunlop): Okay. Thank you very much, then. So now we'll go to the next 30-minute rotation, which will be to the official opposition. Ms. Elliott, you have 30 minutes. You can do a statement for as long as you want, for up to 30 minutes, or you can take a few minutes, do a statement and then ask questions of the minister.

Mrs. Christine Elliott: Good morning, Minister Matthews and Mr. Sapsford. What I would propose to do is just make a brief statement and then there are several questions I would like to ask of Dr. King, given her availability this morning, and then return to questioning—

Hon. Deborah Matthews: She'll be here this afternoon.

Mrs. Christine Elliott: This afternoon? Okay, sorry. All right, then I'll just carry on from the statement.

I am pleased to have the opportunity to address this committee with respect to the very important issues of health and long-term care in the province of Ontario. Much like the minister, who's been in this job only for a few weeks, I've only had a brief tenure as critic as well, so this is very much a learning opportunity for me and I certainly see it as such.

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Health and long-term care are issues that are near and dear to Ontarians and something that I think, as MPPs, all of us hear about in our community offices each and every day. Increasingly, we are hearing from our constituents—

and I do say "we" in the sense of the official opposition, but I think that the members of the NDP and the government are also hearing this—who are very concerned about our health care and long-term-care systems not meeting their needs. This is despite the fact that health care and long-term care is the biggest single expenditure in our budget and despite the so-called health care premium which Ontarians are paying, which is by any measures a health care tax. Ontarians are paying more than $3 billion annually for health care as a result of this tax, yet by virtue of almost every measure they are paying more and receiving less service. I haven't really heard of any single Ontarian who feels that our health care system is better as a result of the McGuinty health tax. In fact, what I have heard is to the contrary: Most Ontarians feel that they are paying more and getting less.

We've certainly heard that our seniors are not receiving the home care placements they deserve. There are many situations where seniors are being placed far away from their spouses in different geographic locations and spouses are not able to visit them; that they're living in homes that desperately need to be upgraded; that we have fast-growing areas in our province that are not being served, and my own home region of Durham certainly is evidence of that; a rapidly growing population where we're underserved in terms of health care services across the board, and I know that is true also in many rural and northern areas.

We also have recently seen a situation where there are a number of patients—and I hear about this again in my community office on almost a daily basis—who are not receiving the medications they need. We've heard about the Avastin situation most recently and that is by no means the only medication situation that we are hearing about.

We also have many hospitals across the province that are in deficit situations and I think we're all waiting for the other shoe to drop, wondering whether they're going to be needing to cut services. I know that is a concern for many hospitals in Ontario.

All of this is against a backdrop of the recently announced virtually $25-billion deficit in Ontario, and, with a 48% drop in corporate revenues, I think this all makes us very concerned about the state of Ontario's economy and, more specifically for the consideration of this committee, the state of health care in Ontario.

Now, we are talking about a number of things and we will be getting into a variety of areas; health care, of course, is such a major area. But I would like to start with questions with respect to some matters that have come up recently—and I think the minister was dealing with some of these in question period yesterday—and that is with respect to a contract with McKinsey and Co. Canada, a $750,000 contract from the Ministry of Health and Long-Term Care to review the Ontario drug benefit plan for seniors and welfare recipients. There seems to be a lot of mystery around this contract and I have a few questions because McKinsey and Co. did a similar report in the UK that recommended that the National Health Service be reduced by 10%. So there's a lot of anxiety around that contract for a variety of reasons.

I would ask, first of all, if the minister could confirm whether or not this contract was tendered, just as a starting point. Was that a sole-source contract or was that a tendered contract?

Hon. Deborah Matthews: That absolutely was sole-source. I don't think anybody is pretending it wasn't. It was let prior to the change in procurement rules.

But let me please make something very clear, as I did in question period. You raised the issue that people are feeling anxiety about that. I think it's a responsibility of all of us to make sure that we don't add fuel to that anxiety. I said yesterday in the Legislature that we are planning absolutely no cuts to seniors, no cuts to people on social assistance. We are actually doing quite the opposite. We are looking at how we can expand availability of drugs to people in Ontario. I think that it's very important that all of us understand and do not try to fuel that anxiety that some may feel. This is a very important initiative for us. We, in Ontario, pay far too much for drugs. We can spend that money more wisely to improve access to drugs for people in this province, and that's what we're committed to doing.

Mrs. Christine Elliott: Minister, can you tell us why there was an initial reluctance to discuss this contract, then?

Hon. Deborah Matthews: This is a contract that—I think it's really important, if we're going to move forward on an initiative that will expand access to drugs, to bring down the cost of drugs in this province, that we do the homework. We are doing that homework now, and we are, as I say, committed to getting the very best value for the taxpayers' dollars spent on health care. We know there's an opportunity within the world of drugs, and that's what we're committed to doing.

Mrs. Christine Elliott: The $750,000 contract with McKinsey and Co.—was that the total cost of the contract for the work or was it broken into components?

Hon. Deborah Matthews: I'll turn to my deputy for that. I'm not sure.

Mr. Ron Sapsford: That was the total cost, and it was set as a maximum amount.

Mrs. Christine Elliott: Okay, for $750,000 to do that?

Mr. Ron Sapsford: Yes.

Mrs. Christine Elliott: Does the ministry have any other contracts with McKinsey and Co. at present or in the past?

Mr. Ron Sapsford: Presently, I would have to check. I don't believe so. Previously, they did some work on the same file several years ago.

Mrs. Christine Elliott: Okay. Would you be able to check? Would you undertake to check—

Mr. Ron Sapsford: Yes, certainly.

Mrs. Christine Elliott: —and to provide us with a list of any contracts that the ministry now has or ever has had with McKinsey and Co. since 2003?

Mr. Ron Sapsford: Since 2003? We'll do our best. Certainly current contracts—we can provide that information.

Hon. Deborah Matthews: I do feel the need to respond to one of the comments you made in your introduction. You said that, no matter how you measure it, Ontarians are getting worse health care. That is simply not true. In fact, we have put a high value on measuring results. That is why, since we've been elected in 2003, we actually measure wait times. When we were elected, we knew anecdotally that people were waiting a long time for hips and knees, for cardiac surgery, for cancer surgery. We heard anecdotally about it, but we didn't measure it across the province. Now we not only measure it, we've set provincial targets that are based on the evidence that this is a medically acceptable time in which someone should get a procedure, and we post online, publicly available to everyone, what the wait times are in each of the hospitals across the province. We have measured it. We have seen extraordinary success in the reduction of wait times, and it's publicly available.

You talk about, "There's no measurable improvement. In fact, it's worse when it comes to long-term-care homes." We've made enormous investments in long-term homes. We've raised the standards. We've increased the number of beds. We're engaged in a redevelopment so that the homes are more comfortable for people.

When it comes to access to family doctors, we heard stories—you must have heard them too; I sure did—about people desperate to get attached to a primary health care provider. We now actually have a system that connects those patients who need access with physicians, and we're achieving very good success making those matches.

I don't think there is anything you could point to that would actually say that health care is anything but significantly better than it was when we took office. And if you have ways to measure that, if you have evidence to support that claim, I'd be really interested to see it, because all of the ways we have measured it have shown significant, measurable, meaningful improvement to health care in this province.

The Chair (Mr. Garfield Dunlop): Minister, I didn't cut you off this time, but that's the sort of thing you would respond to you in your second 30 minutes—

Hon. Deborah Matthews: Okay, I'll do it again, then.

Laughter.

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The Chair (Mr. Garfield Dunlop): All right, thank you.

Hon. Deborah Matthews: All right. I appreciate that, Chair.

Mrs. Christine Elliott: Thank you. I'll leave my comments with respect to some of those specific issues that you mentioned, Minister, for another line of questioning. But just carrying on with the McKinsey contract, have there ever been contracts with McKinsey that have been paid for not out of the Ministry of Health budgets, but out of any hospital budgets?

Hon. Deborah Matthews: Deputy?

Mr. Ron Sapsford: If hospitals have used external consultants, that would be their decision. If you're asking if they have been done on behalf of the ministry, to my knowledge, no.

Mrs. Christine Elliott: So to your knowledge, no hospitals have been directed to pay any McKinsey consulting fees through their budgets.

Mr. Ron Sapsford: By the ministry?

Mrs. Christine Elliott: Yes.

Mr. Ron Sapsford: No.

Mrs. Christine Elliott: Would you undertake to check that?

Mr. Ron Sapsford: To verify that?

Mrs. Christine Elliott: Yes.

Mr. Ron Sapsford: Certainly.

Mrs. Christine Elliott: Okay, thank you.

With respect to any other consultants' contracts, have they—to your knowledge again, if could you check not just McKinsey, but any other consultants' contracts that have been paid for through hospital budgets—that were contracted through the Ministry of Health, I should say.

Mr. Ron Sapsford: Right. All hospital revenue is transferred to hospitals, and then specific use of that money would be in the hands of the hospitals. So I'm not sure if I'm following your question as to what you'd like.

Mrs. Christine Elliott: What I'm concerned about is whether there have been any consultants' contracts that have been negotiated by the Ministry of Health where there has been direction to hospitals to pay all or any part of the cost of the consultants' fees.

Mr. Ron Sapsford: Negotiated by the ministry, okay. I can verify that for you.

Mrs. Christine Elliott: Yes, thank you.

Minister, can you tell us what the status is of the McKinsey report and where it is at this point?

Hon. Deborah Matthews: Yes. As I said, there is no question that Ontarians are paying too much for drugs. We made some good progress with Bill 102, but I do believe that there is more to do when it comes to getting the best possible value for taxpayers' dollars. We are very carefully looking at what some options might be to continue to expand access to drugs and drive down the costs of drugs in this province. Obviously, that is work that we are doing, and I think it's very, very important work.

As MPPs, we are approached by people in our constituencies who are advocating for expanded access to drugs. We have a very rigorous program here where we've removed from politicians the decisions about what drugs are covered through the ODB and put them into the hands of experts. We have a very rigorous process whereby each drug is looked at very carefully—is this good value for money and will this do what we need it to do, from a public health consideration?

I think it's the right process, but as our researchers come up with new drugs, new pharmaceuticals, we want to be in a position where we can offer them to people who rely on the Ontario drug benefit program for their

medications. We want to be able to expand that. In order to do that, we need to drive down the prices of some of the other drugs.

Mrs. Christine Elliott: Have you set a time frame for the completion of the review?

Hon. Deborah Matthews: No.

Mrs. Christine Elliott: Can you give us any kind of an idea in terms of time in general for the report?

Hon. Deborah Matthews: We're going to make sure we do it right. You will hear about it as soon as we're ready to move on it.

Mrs. Christine Elliott: Fair enough. Will you undertake to provide us with a copy as soon as it has been provided to you?

Hon. Deborah Matthews: Clearly, as soon as we're ready to move, you'll have access to the information that we can provide.

Mrs. Christine Elliott: Okay. There was one question that I was asked to ask you and it specifically relates to the H1N1 vaccine. Can you assure Ontarians that you're not intending to implement any strategies that would deny Ontario pharmacists the ability to receive and supply the H1N1 vaccine in particular?

Hon. Deborah Matthews: I can absolutely make that assurance. We are very committed to getting every Ontarian vaccinated, so that's a high priority—a very high priority—for us. Each of our public health units is looking after the distribution of the vaccine in their own communities. This is work that they're actually well-positioned to do, because we have a very effective seasonal vaccine strategy here in Ontario, so our public health units are used to the distribution of vaccine to the broader public, unlike some other jurisdictions.

We have a very well-organized, very well-planned delivery system of the H1N1 vaccine and we are doing everything we can to get the word out to people that it's safe and that it's important, not just for them, but for all of the people around them: for their family members, for their co-workers, for the people they work with every day and the people in their communities. So I will take this opportunity as a little plug, urging people to get the H1N1 vaccine. It's very important.

Mrs. Christine Elliott: Thank you.

I'd like to turn now to the 10-year strategic plan for health. In preparing for this committee, I happened to take a look at some of the questions that were asked by my predecessor, Mrs. Witmer, of your predecessor, Minister Smitherman, with respect to the completion of the 10-year strategic plan. It's far behind schedule. It was to have been delivered in 2008. Can you comment on when we can expect to see it, what the status is and when it will be released?

Hon. Deborah Matthews: I can tell you that as I have started to immerse myself in the information in this ministry, I think it's an area where clearly we have not delivered what we undertook to deliver. Having said that, we have very clearly laid out goals for our ministry, so we know where we're going moving forward: better access to care and shorter wait times—a particular focus on ER wait times right now, but not losing sight of wait times for the other procedures that we are measuring and reporting publicly on. So I think we have the components of that strategy and we will continue to work toward that.

Mrs. Christine Elliott: Has the plan been finalized, then?

Hon. Deborah Matthews: No.

Mrs. Christine Elliott: Is there a time frame that you can commit to at this point?

Hon. Deborah Matthews: I think, as a new minister, it's important that I have input into that, so I will take time to make sure that the elements in that strategic plan are elements that I think are appropriate at this time in our economic reality.

I know that every day at question period we have questions about spending and we have questions about cutting. I think that the reality is that we have a very high deficit today. I don't think anybody will pretend that is not a deficit that we'll—a lot of work will have to go into bringing down that deficit over time. Health care being as big a ministry as it is, part of our strategic plan has to recognize the fiscal reality that we live in right now. At this stage of the game we are beginning to understand what that might mean.

Mrs. Christine Elliott: I guess in terms of our fiscal reality now, it's all the more important to accelerate the production of the strategic plan, given how important it is to the work of the LHINs, for example. The work that they do is contingent upon direction from the ministry. Under what direction are the LHINs functioning now if they don't have the strategic plan?

Hon. Deborah Matthews: The LHINs have very clear direction right now. Their highest priority is our ER/ALC strategy. LHINs are perfectly positioned to implement that strategy on the ground, because they have connections to all the various community agencies—the CCACs, Meals on Wheels, home support organizations. They really can at the community level, in a way that we could never do out of our ministry corporate offices, drive that collaboration that will result in people staying in their homes longer, to get the supports they need; to get the caregivers the support they need to keep people in their homes as long as possible, which will reduce the pressure on the hospitals.

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The LHINs have a critical role. They are all working very hard to deliver that collaborative approach that is essential for us to—we all need to work together to support people who are perhaps not quite able to look after themselves, who are thinking maybe the next step for them—and the next step soon—is into a long-term-care home. If we can keep people in their homes as long as possible, that will help the system and, of course, it's a much better quality of life for people. People want to stay at home as long as they can and we need to support people to be able to do that. So the LHINs are now absolutely focused on delivering the results in emergency room wait times and alternate levels of care.

Let me give you one little example of what a LHIN has done in my community. I apologize for using my community, but it's what I know best.

We now have a nurse in the emergency department at University Hospital in London. If someone comes into the emergency department and if there is a possibility that they could go home with the right supports, her job is to actually divert that person from admission into the hospital and into the right supports in the community. She has the ability to draw from a number of different organizations and supports that will really enhance the quality of life for that person and take pressure off the hospital.

What we had before the focus on local health integration was a number of different silos that weren't coordinated in their response to the individual. We talk about patient-centred care. I think the LHINs really understand how to deliver that patient-centred care. They do an evaluation of a particular patient, understand the array of supports that are available in the community—perhaps some volunteer supports, some paid supports, some family supports—and they provide the right constellation of supports for that person.

Mrs. Christine Elliott: Thank you. I'd like to just get back to the development of the plan itself. Can you tell me who is currently working on it? Besides your staff, are there any consultants being engaged with respect to this plan?

Hon. Deborah Matthews: Deputy?

Mr. Ron Sapsford: No. At the beginning of the process, to be clear, we secured several research papers, I'll call them, most of them from the academic community. There were small expenditures in order to support that, but the basic work of the development of the plan has been internal to the Ministry of Health and Long-Term Care.

Mrs. Christine Elliott: Would you be able to provide us with information relating to any consultants who were engaged with respect to the plan, Mr. Sapsford?

Mr. Ron Sapsford: Certainly.

Mrs. Christine Elliott: Thank you. And invoices as well?

Mr. Ron Sapsford: I can give you the details of what they were and the amounts that were paid.

Mrs. Christine Elliott: Thank you.

Mr. Ron Sapsford: As I said, I think almost all of them were related to academic research papers, but I'll provide the information.

Mrs. Christine Elliott: Okay, thank you. Do you anticipate, just given the work that's on the plan—I'm sorry to keep coming back to timelines. Do you anticipate that the plan will be released by the end of 2009?

Hon. Deborah Matthews: I can't commit to that, no.

Mrs. Christine Elliott: Is there anything specific that you know of that will result in the plan cutting services across the board in any particular area? Are you able to give us any indication of what's in the plan at the current time?

Hon. Deborah Matthews: I think you probably heard what the Premier had to say after the fall economic statement, that we are committed to health care in this province, that we are committed to increasing and improving access to health care and health care services. We are not looking at cuts.

Mrs. Christine Elliott: Just going back to some of the comments that you made in your introductory comments, you did indicate that the implementation of some programs may take longer than anticipated, given the current economic climate. Can you comment, at this point, on which program implementations might be delayed?

Hon. Deborah Matthews: Yes, I think the commitment of 9,000 new nurses is one that we've been very transparent about. That is something that is going to take a little bit longer. We've made good progress—I forget the number of how many more nurses are working in the province today than six years ago—but that is one that will take a little bit longer.

Mrs. Christine Elliott: Are there any other areas that at this point you anticipate may take longer to implement?

Hon. Deborah Matthews: None that I'm thinking of right now, so I'll see if there are more that we've already committed to.

Mrs. Christine Elliott: In terms of some of the comments that you made with respect to long-term-care placements and so on, we are hearing increasingly of people almost being warehoused in hospitals because they can't find adequate long-term-care placements. I do agree with you that the aging at home strategy is preferable for many people, but can you tell us what plans, if any, there are to specifically address both of those situations in monetary terms, both in putting more money into the aging at home strategy and in terms of refurbishing and building new long-term-care placements?

Hon. Deborah Matthews: Yes, and I will turn to my deputy for the right numbers on this, but I think it's safe to say that again, prior to our election in 2003, there were virtually no new long-term-care beds being built—correct me if I'm wrong—in long-term-care homes. I believe we have approximately 7,000 new long-term-care beds, either under development or in construction now. Obviously, it takes time to go from the decision to move forward with that kind of aggressive expansion of long-term-care beds to the time the beds actually open, but we're in very good shape as we move forward to get those new long-term-care beds open.

The planning, frankly, had not been done. I'm a demographer; that's what I was before I was elected. I understand as well as anybody the increased demands on our health care system, including long-term care, as we move forward. Having the right services in place for people as they age across the province is a very high priority for me. You'll hear me talk about having a sustainable health care system. It's because I know we're going to have more and more people needing to access the health care system as our population ages.

We know that people are living longer, and at the end of their life they need more supports. We need to be there for them. So we're moving aggressively on building new long-term-care beds right across the province. We're also committed to refurbishing some of the accommodations

that frankly don't meet the needs of people today. We have all probably visited those kinds of homes in our communities and they simply aren't the kinds of places where we would feel comfortable placing our parents. So we are refurbishing, we are building new, we're investing significant amounts of money in it, and as we look forward, this is going to be an area where we're going to have to continue to focus.

The Chair (Mr. Garfield Dunlop): That really brings us to the end of the time for the official opposition. Thank you very much. We'll now move to the third party. Ms. Gélinas, go ahead.

M^me^ France Gélinas: Thank you. First, I want to—

Interruption.

The Chair (Mr. Garfield Dunlop): If I could ask everyone to speak up a little more than normal. We've had a constant construction program here all fall, and you can probably hear it out back right now. So speak as loud as you can, please. Thank you.

M^me^ France Gélinas: I can do that. Am I loud enough now?

The Chair (Mr. Garfield Dunlop): Yes.

M^me^ France Gélinas: All right.

I want to thank the minister. Thank you very much for your comments. I do realize that the Ministry of Health and Long-Term Care is huge. You haven't been there very long, but so far you've done very well.

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Hon. Deborah Matthews: Thank you.

M^me^ France Gélinas: Hang in there. It'll get easier. I do see a lot of helpers behind you, though, so if there are questions that you have not been briefed on, I would certainly be happy to hear their response, if that makes it easier for you.

I haven't got much political experience, but I do have 25 years' experience as a health care worker. I still believe that Ontario has an excellent health care system that tries really hard to meet the needs of everybody who comes to the system for help and for care. There is a huge amount of taxpayer dollars going to sustain the health care system—over $40 billion of it. I'm not sure we're always getting the full value for our investment, so I agree with you that results should be measured in quality of care and improvement to people's health and not necessarily in how much we've invested.

But we are here today to talk about the investment that your ministry has made in a different part. Just to give you an idea, the part of the system that we will be asking for accountability and more details on will be primary care, long-term care, home care—I have to touch on hospitals, they're just so big—and hopefully les services en français through all of this.

I'd like to start with a line of questioning and basically get out of the way some of the questions that are presently in the media, just to get your opinion. You're a new minister. You came at a time when health care made the headlines for the wrong reasons—not for praising the high-quality care we offered in Ontario, but quite the opposite. So, just to see.

Ron, I'll start with a question that has to do with you—don't take it personally or anything; it was in the media. An example of a high-ranking civil servant being paid out of hospitals has come to light. It was on the front page of the paper, pretty hard to miss. Ron, your deputy minister, was an example that has been cited, and Hugh MacLeod, a policy advisor to the Premier, has also been mentioned.

My first question has to do with—I don't know if you've been briefed on this or not, but if you haven't, then so be it. Do you know how long it's been going on? Do you know how common it is? If we were to look down the ranks of the assistant deputy ministers as the—I see a whole bunch of top civil servants here on my list, heads of agencies etc. Do you know how often this practice is used, and your opinion of it?

Hon. Deborah Matthews: No, I don't know how many people, but we could certainly find that out. I'm sure you noticed that the Premier said that there will be a change in how these salaries are reported, so that now if someone like my deputy, for example, is paid through another organization, he will appear on the sunshine list in the ministry. I think that's an important step toward the transparency that we all acknowledge is the right thing to do.

M^me^ France Gélinas: I realize that you don't know how many. From my experience, it is quite common for heads of agencies within your ministry, who are funded by your ministry, to use this. I would be curious to have a little bit of an analysis from your ministry as to the reasons that motivate this. People always jump through bad intent—wanting to hide or get away with something or wanting to pay more than the salary grid. I would like to know, from the ministry's perspective, what has motivated this and to what extent. It's a good step to put it on the sunshine list, but if all we do is put it on the sunshine list, it doesn't change the numbers that are there and it still leaves the public with an idea that it was done with malicious intent until we give them the reason as to why the ministry is doing this. My experience is that it is quite common, not only with the top civil servants, but at agencies, boards and commissions, as well as your ministry. You will find that quite a few of them are paid outside of the ministry envelope through transfer payment agencies, mainly hospitals, but sometimes it's universities and sometimes it's other big transfer payment agencies of the government. Would you be willing to do that?

Hon. Deborah Matthews: Yes, I think that's something we can do. As I say, they would be on the sunshine list now. I suspect that not too many of them are paid under $100,000 a year, so they would all appear on the sunshine list. That would be a pretty straightforward exercise.

Deputy, do you have anything to add to this?

Mr. Ron Sapsford: We can certainly prepare some information on the rationale.

In terms of the length of time, it's as long as I can remember, so that's going back 15, 20 years. The notion

of secondment in and out of the government is not a new notion by any stretch of the imagination. It tends to focus on health because of the subject matter involved and sometimes the knowledge and expertise required. But we can pull something together on that question.

M^me^ France Gélinas: Thank you.

Hon. Deborah Matthews: I believe that Michael Decter, who was the deputy in health under the NDP government, may have been the first.

This is a very large entity; as you say, a budget of over $40 billion. We can do a better job if we do have some people coming in from, for example, the health care sector, from hospitals, from other places. I think the notion of secondment is a good idea for the health of the ministry.

We'll get you the information that you're looking for.

M^me^ France Gélinas: Okay, thank you. Another bit of information that made the headlines was the use of consultants by your ministry. I'd like to have a written—if you know it off the top of your head, I'll be impressed, but if you don't, I'd like to get it, as to how much the Ministry of Health and Long-Term Care paid for consultants last year and how much have you budgeted for consultants for next year, as well as the decision-making criteria as to, "Are we going to have this done in-house or are we going to hire a consultant to do a piece of work?" Do you know off the top of your head?

Hon. Deborah Matthews: I do not know off the top of my head; I'm sorry. We will get you the information that we can get to you.

I do want to make a comment, though, about the use of consultants generally. I think that we have seen an overdependence on the use of consultants, and I think what we've seen in eHealth is that we actually are able to significantly reduce the number of consultants. That's obviously the direction that we're going in, but I do think it's important to acknowledge that there is an important role for consultants. Sometimes, when it is a project where you don't have the expertise in-house, you do look outside to get that kind of project focus, or fresh eyes on a problem. So I think there's a very important role for consultants.

We've changed the procurement rules, so there will be no more sole-sourcing. I think that was an issue that people were concerned about. We're actively reducing the number of consultants, but I don't want anybody to leave here with the impression that consultants don't play a pretty valuable role in the ministry.

M^me^ France Gélinas: You've answered part of my question as to—

Hon. Deborah Matthews: When would we choose.

M^me^ France Gélinas: —what the decision-making criteria would be. You're going for expertise, you're going for fresh eyes. Would you also say that you get consultants when the civil service is overworked or just cannot handle any more?

Mr. Ron Sapsford: I think that's a reasonable comment. There are a variety of reasons for that. Sometimes it's specialized expertise that the ministry judges that it doesn't have. In some cases, if there are special projects or additional workload added for a very specific purpose. In terms of the ministry's staff strength, we may focus on that as an individual project. In some cases, a piece of work needs to be done at a fairly rapid rate, so supplementing the work of ministry staff with some external expertise to do certain pieces of the work would be another case where we might look at external support.

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Oftentimes what people call consultants are nothing more than knowledgeable people in the health care system who can bring into the discussion of an issue or a policy discussion some specialized expertise and assistance. The notion of secondments that you raised earlier is often a type of consulting service, in my view; you're looking for specialized expertise to carry a piece of work forward. The use of the word "consultant" is sometimes broadened to mean anyone who isn't employed by the ministry, and I think it's important to differentiate between those uses. For instance, the previous question, did we use consultants for the strategic plan development? By definition, yes, we used external people who had expertise in certain areas of health care. Most of those, as I said, were in the academic community, and we paid an amount of money to get a piece of work done. Is that a consultant? Is that a piece of expertise from the health care system that we used to supplement the work of the ministry?

Those are some of the factors that go into those decisions. From my perspective, they're either related to a project that's been added to the workload or, more importantly, the kind of expertise we need to carry a piece of work forward.

M^me^ France Gélinas: With the view, again, of clearing the air of what happened before you were there, of the consultant contracts that happened last year, can I find out how many of them have been tendered and how many were untendered, with the total value of dollars that were spent? I've asked for just a little bit more detail about those and what they were for, in general terms.

Mr. Ron Sapsford: Yes. If you're asking for a detailed listing, that will take some time, but in terms of being able to categorize the sole-source versus tendered versus VOR and what the total contract values are and some description of the kind of work, yes, I can do that.

M^me^ France Gélinas: Okay, thank you. I would appreciate it.

Another one that kind of is still there and I would like it to go away is the consultant agencies that were involved with eHealth and the scandal surrounding it. Can we find out if any of those consultants presently have work with the Ministry of Health and Long-Term Care, how many contracts they have, what is the dollar value and if these people are still around?

Mr. Ron Sapsford: Well, if you could be a little more precise—

M^me^ France Gélinas: It's not very often you're speechless.

Mr. Ron Sapsford: Well, no. It's simply you've asked me the list of consultants that were involved in the scandal and—

M^me^ France Gélinas: No, let's just—

Mr. Ron Sapsford: You're asking me to draw that conclusion, and I can't do that.

M^me^ France Gélinas: To be fair, then, the people who were consultants and got contracts with eHealth in their last year of work, because the agency hasn't been there that long under that name. Of those consultants, are they working for you at the Ministry of Health right now? No judgment as to the quality of their work, just who they are.

Mr. Ron Sapsford: I would have to check. I want to be quite precise about that.

M^me^ France Gélinas: Sure.

Mr. Ron Sapsford: Any work related to eHealth, however, there may be a couple who are finishing in the ministry, but the bulk of those agreements were transferred to eHealth Ontario on April 1, 2009. As you've said, consultants who were working in the ministry on these projects are no longer working in the Ministry of Health. They were moved entirely to the eHealth agency. It's possible, and this is what I would have to check, that there may be other pieces of work unrelated to eHealth that they may be involved in, and that would be the verification that I would do. Is that clear?

M^me^ France Gélinas: This is what I would like to find out.

The other piece—I have no idea if we have access to this information, so fill me in. We'll start with the transfer payment agency, but I'm interested in agencies, boards and commissions. Transfer payment agencies funded by the Ministry of Health, do they report to you as to how much money and how many contracts they spend on consultants? Do you know this in the normal reporting that happens? Start with transfer payment agencies.

Mr. Ron Sapsford: No.

M^me^ France Gélinas: It's not something that you're interested in knowing or—

Mr. Ron Sapsford: In terms of transfer payment agencies, there is a whole series of guidelines about accountability and reporting requirements. Specific reporting of consultant agreements is not part of that framework, so it's not a normal and routine part of the reporting.

M^me^ France Gélinas: Would your answer also stand for boards and commissions?

Mr. Ron Sapsford: Yes. To my knowledge, again, the agency criteria do not specifically include that piece of reporting as to contracts that a specific agency has. That would be similar.

The requirements for agencies, of course, are more specific criteria about accountability mechanisms. The rules around procurement for agencies are dictated more directly by the government. For transfer payment agencies, there is less direct supervision of their procurement policies, although there's always an expectation that best practices are used in transfer payment agencies as well.

M^me^ France Gélinas: Given what we know now, is this something that your ministry will look at asking in their accountability agreement so that we know either the amount of money that was spent on consultants or the number of consultants? Are you interested in knowing? I am; I want to know if you are.

The Chair (Mr. Garfield Dunlop): We've just got a couple of minutes left before we go to recess, okay?

M^me^ France Gélinas: I know.

Mr. Ron Sapsford: The transfer payment guidelines are corporate, so they're not only related to the Ministry of Health; they apply across the whole government. Reporting this kind of information I know is probably going to be under discussion, but at the moment it is not a requirement.

M^me^ France Gélinas: It's not a requirement. Would you consider asking for this?

Mr. Ron Sapsford: I think your question is more about transparency and public reporting. Whether or not I'm interested in seeing every single contract that's left by every single hospital and transfer payment agent—don't forget, we've got thousands of transfer payment agents across the whole government.

For me, reporting all that information to the ministry implies we do something with it. I think the intent of your question is that there should be some public transparency around that. Whether it's actually reported to the ministry for some kind of a review or monitoring or whether it's publicly reported so that there's more transparency would seem to me to be the issue that we would look at carefully.

M^me^ France Gélinas: I appreciated, Madam Minister, that when you opened, you did mention that there has been a reliance on consultants, and they do do good work, invaluable work in some instances, but we shouldn't be overdependent on them. I think the same would apply to a lot of your transfer payment agencies. It could be an intent that you share with them as well and make it available, maybe not necessarily in a reporting fashion, but at least having that information available would be a form of accountability for the taxpayers.

The Chair (Mr. Garfield Dunlop): Okay, that's what we can handle right now. We will recess at this point until after routine proceedings this afternoon.

Thank you very much, everyone. We'll see you later on.

The committee recessed from 1020 to 1600.

The Chair (Mr. Garfield Dunlop): Thank you very much, ladies and gentlemen. This afternoon I'd like to welcome back the minister and the staff of the Ministry of Health and Long-Term Care.

Mr. Khalil Ramal: Mr. Chair?

The Chair (Mr. Garfield Dunlop): Go ahead.

Mr. Khalil Ramal: Can I ask for unanimous consent to allow the chief medical officer to come forward and speak to the committee before Ms. Gélinas's 10 minutes—

The Chair (Mr. Garfield Dunlop): Yes, we understand that the minister has set aside her 30 minutes for now and the third party has set aside their remaining 10 minutes to let the chief medical officer of health answer questions. Do we have unanimous consent on that? Agreed? Okay.

We will start off with Ms. Elliott from the official opposition. You have 20 minutes so you can ask questions to the chief medical officer of health. Welcome, Dr. King.

Mrs. Christine Elliott: Thank you very much, Dr. King, for being here today to answer a few questions. I understand that you might want to take a few moments just to give us a brief statement about some issues that you're dealing with presently. If you'd like to start with that, by all means.

Dr. Arlene King: Yes, thank you very much. For those of you I haven't met, my name is Dr. Arlene King and I'm the chief medical officer of health for the province of Ontario. I thought you might be interested in an update on the H1N1 flu situation here in the province of Ontario.

First of all, influenza activity in the province due to H1N1 is continuing to increase. More people are visiting their health care providers with influenza-like illness and more people are being hospitalized with complications from the flu in Ontario. We believe that this in fact does mark the arrival of the second wave of H1N1 in the province, as we expected.

The H1N1 immunization campaign is currently underway across the province and, following last week's approval of a vaccine by the federal government, Ontario has received approximately 1.7 million doses of H1N1 vaccine. This supply has been allocated and shipped to public health units, enabling them to begin immunizing Ontarians this week.

We are continuing to get real-time information on the availability of the vaccine from the federal government as both the procurer and the regulator, as well as more information from GlaxoSmithKline. Ultimately, there will be enough vaccine for everyone who needs and wants it.

Yesterday, local public health units launched clinics across the province on the basis of local need, resources and logistics. This week, the vaccine is being offered to those who will benefit the most first. These include pregnant women; people 65 and under with chronic conditions; healthy children six months to under five years of age; health care workers; household contacts and care providers of persons at high risk who cannot be immunized or those whose immune system cannot develop a good level of protection from the vaccine; and people living in remote or isolated communities. Next week, assuming that we have enough vaccine, we intend to broaden the immunization program to others in Ontario.

I really want to encourage parents to get their school-aged children immunized against the H1N1 flu. As you know, this is a vulnerable group, and the circumstances in which children gather and their personal behaviours are important predictors of transmission. So it is important that we address that population as soon as we can.

In fact, of course, I will strongly encourage everyone in this province to get a flu shot. To do that, we have launched print, radio and online advertising. We're using the media to get the word out that the vaccine is safe and the best way to protect ourselves, our families and everyone else around us.

As for our other activities, the ministry is actively generating guidance documents for a variety of health and non-health settings for the public with scientific and technical support coming from the Ontario Agency for Health Protection and Promotion, along with input from the public health field and medical experts in the province of Ontario.

We have distributed our stockpile of antivirals to community pharmacies to enable timely and equitable access to treatment within 48 hours. By the end of the week, all pharmacies will have some of the provincial supply. This includes a special pediatric Tamiflu formulation that will help mitigate some of the global issues related to the supply of the pediatric formulation.

The ministry is also enabling its four-week emergency stockpile of personal protective equipment and infection-control supplies to health care providers. In addition, due to growing H1N1 flu activity in the community, local planners are currently preparing for the establishment of flu centres to help offset the pressure on primary care and emergency departments from the growing number of flu patients and until more of the population can be immunized.

The ministry is continuing to procure supplies, equipment and services on an urgent basis to support the response to H1N1, and this includes needles and syringes to support the mass immunization efforts, additional ventilators to expand critical care capacity in hospitals, as well as distribution services to help manage the logistics of deploying the ministry's stockpile of antivirals to community pharmacies.

In terms of costs, approximately $4.7 million was incurred during the initial response to H1N1 between April and June. However, we expect the total cost of the pandemic response will be in the several hundred-million-dollar range. We have communicated a range of $450 million to $650 million. However, this will depend largely on the costs of the immunization program, and with continued planning and response activities we will continue to refine these estimates on a regular basis.

Our estimates do not include expected increases in health care costs and costs incurred by health providers during a pandemic, such as public health units, health care providers through LHINs and claims to OHIP. They also do not account for recovery costs, such as replenishing ministry stockpiles.

It is difficult to estimate such costs ahead of time as they really do depend on the response required to address an evolving situation that is presented to us by this novel influenza virus. However, we are continuing to monitor and refine our estimates as the situation unfolds.

Recent negotiations with the federal government have resulted in an agreement on cost-sharing in two areas: the cost of vaccine procurement and the replacement of antiviral stockpiles. The federal government will contribute 60% of the cost for both items.

Thank you very much, Mr. Chair, for the opportunity to address the estimates committee.

The Chair (Mr. Garfield Dunlop): Thank you very much, Dr. King. I appreciate very much you coming out today at a time in your career that is probably one of the most pressure-cooker you could find.

Ms. Elliott, you can continue on with the questioning, if you will.

Mrs. Christine Elliott: Thank you again, Dr. King. I only have a few questions, really, several on pandemic preparedness. Do you have any concerns in any parts of Ontario with respect to our preparedness for the second wave of H1N1?

Dr. Arlene King: Well, one of the areas where the populations are quite vulnerable is in fact in our remote and isolated communities, and we're working very closely with Health Canada on that issue. Again, I think that everyone has really been mounting a good response to date, and the co-operation between the two levels of government has been particularly good.

That is one population, though, that we're concerned about and why we've mobilized an immunization program in the first priority groups against those who are residing in our remote and isolated communities. In fact, we uploaded vaccine to that area because of the distance, because it takes two or three days to get vaccine. So with our first shipment we actually provided a little more vaccine there. I think that's one area we'll be watching closely. As we know, there have been some challenges in some other parts of the country, and we are working closely with the First Nations communities and Health Canada to address that population.

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Mrs. Christine Elliott: Could you comment on the level of preparedness in some of the long-term-care facilities?

Dr. Arlene King: Yes. I think that Ontario is in a privileged position, in some ways, because we implemented 10 years ago a universal influenza immunization program. These facilities are particularly used to mounting an immunization campaign and they also are used to managing outbreaks. Interestingly, because this flu pandemic is a little bit different—it's affecting younger people more—we're not seeing outbreaks due to H1N1 in that facility. That being said, I am really quite confident that that area will be well managed because of the experience they have with managing regular seasonal flu.

Mrs. Christine Elliott: Are you satisfied that everything in the pandemic plan that should have been done has been done provincially?

Dr. Arlene King: Yes, and although this pandemic has been a little bit different than what we expected, we are using the pandemic plan as the basis of our response, both at a national level and at a provincial level. The level of federal-provincial-territorial collaboration, I think, has been unprecedented. We meet several times a week, the different levels. So I would say, yes. Of course, there are always bumps and twists in the road; there are new things happening every day. But we've got a good, responsive system and a good relationship with health authorities. It's really important that we all work together as a team.

Mrs. Christine Elliott: Great. Just a couple of questions on a different topic: The next question is with respect to C. difficile and hospital infections. Do you see a need to be reporting deaths as well as infection rates?

Dr. Arlene King: Again, I think the reporting related to hospital infection control is something that we're continuing to look at and what some of the reporting parameters are. I have to say that we are looking at this on an ongoing basis. It's something that we will continue to look at, though I haven't had as much time to drill down into some of these other areas as I would have liked because I've been dealing primarily with H1N1. But I think it's an important point you're raising and one that we'll look at.

Mrs. Christine Elliott: Okay. I recognize that you are extremely busy right now.

On another topic, if I could ask about the health effects of wind turbines. Do you have any comment with respect to that, whether you have any concerns with respect to that issue or if you have any recommendations to make to us on that issue.

Dr. Arlene King: Yes. In fact, we have been having ongoing discussions with the Ontario Agency for Health Protection. I actually met with them earlier today about this issue. What we'll be doing, when time permits—and I have to say when time permits—is having a thorough discussion with all of the medical officers of health in this province about the existing information we have on any possible health effects related to wind turbines and determining whether any additional research needs to be done. I understand there's a research chair being established here in the province to address these kinds of issues. That will, in fact, enable us to do more research on this issue, but I would anticipate that shortly we will come forward—I can't give you a timeline on that because we're all very busy managing the H1N1 response—with a view on the issue of any possible health effects related to wind turbines and what further work needs to be done in this area.

Mrs. Christine Elliott: So at the moment you don't have a formal position—

Dr. Arlene King: No, we're still reviewing the situation and I'm discussing it with the Ontario agency.

Mrs. Christine Elliott: Do you think it's important that a view be determined before any further new construction of wind turbines happens? Are you concerned to that extent? How worried should we be about it?

Dr. Arlene King: Again, we are having further discussions on this area, and when I am ready to say more about this issue, we will do that. At this point, I really cannot say anything more about it.

Mrs. Christine Elliott: Okay.

Mr. Ted Chudleigh: What would you see as a time frame for that?

Dr. Arlene King: Realistically, it will probably be a couple of months, just in light of the fact that everybody in the province is completely preoccupied with trying to mount an H1N1 response. Resources are being, of course, diverted to address the H1N1 response. Again, realistically, we're looking at six to eight weeks, I think. We had a discussion about it this morning.

Mr. Ted Chudleigh: If I could go back to H1N1 for a moment, you mentioned that you're relying on the media to talk about the safety of the vaccine. I have concern in that area. A lot of the discussion—I think on the most-listened-to drive time show in the morning, there was a discussion on it. Initially, one said that he was not going to take it, and by the time they finished the discussion, he modified that to say he was going to think long and hard about it. It didn't give one a lot of confidence. Also, on CHCH News one evening, I heard some concern expressed about the safety of the H1N1 vaccine.

I know that when I took a microbiology course at university, it was by far the toughest course I ever took at university, and my grade reflected that toughness. I don't pretend to be an expert in that microbiology field, but I do understand that it would be very, very difficult for this vaccine not to be safe. I think I understand that much.

I wondered, since the media may not be doing the province and the vulnerable groups a favour in this area, if you had a follow-up plan for that.

Dr. Arlene King: Yes. I'm sorry if my statement led you to believe that we're asking the media to talk about this. As chief medical officers of health and medical officers of health, we are all really attempting to communicate as frequently as we can with the public around the safety of this vaccine.

I think the first point is that "fast track" does not mean "shortcut" in terms of the regulation of this product. I am really extremely confident in the work of our regulators at Health Canada. I worked with them for 10 years and I was the director general of immunization. I know this group well. They do an excellent job of managing; they are world renowned in terms of regulation of our vaccines. In addition to reviewing all of the clinical studies, every lot that comes off the assembly line is looked at for quality. That is one of the rate-limiting steps in terms of getting vaccine, but it's really important that that be done. So from the regulatory perspective, I have absolute confidence in our regulators.

I think one of the challenges is trying to counter some of the myths that prevail around immunization. This vaccine is safe; it's effective. In fact, the immunogenicity of this vaccine, meaning the ability of the vaccine to create a stronger immune response, is over 90%. With our regular seasonal vaccines, it's about 70%. This adjuvanted vaccine, with its immune-boosting component, enables a more robust response to the vaccine.

We have a robust post-marketing surveillance strategy in place as well because, of course, with a new vaccine, there's only a limited amount of data you have before you release the product. Therefore, post-marketing surveillance will be a very important component of the safety monitoring program.

I think the challenge is communication. We have questions and answers that are available around the vaccine. We're using those as part of our informed consent process. There are very few contra-indications or reasons why people cannot be immunized—really, it's preceding severe allergic reactions to some component of the vaccine, which is extremely rare. There are a few others as well, but most people will be able to accept this, mount a good immune response and have a safe experience with it. Sore arms will be not infrequent with it, which they often are with vaccines. But besides sore arms and a bit of redness, by and large we expect this to be a safe product.

Mr. Ted Chudleigh: You mentioned as well that the range of the cost is somewhere between $400 million, I think, and $650 million. Is that solely dependent on the uptake?

Dr. Arlene King: No, it isn't. It's actually going to be largely dependent on how many doses we have to give. As you may know, we started out—

Mr. Ted Chudleigh: Wouldn't that be the uptake?

Dr. Arlene King: Yes, to a degree, although the clinics and the manpower will be there to deliver the product. It will be adjusted, of course, depending on what kind of demand there is.

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But the information on the number of doses is evolving, and initially we thought that we would probably have to administer two doses of product to everyone. We now know that people 10 and over will only need one, and it may be—so the chief public health officer of Canada tells us—that there are some emerging data to suggest that maybe we'll only need one dose in children, which will be good news. That is very preliminary, we don't know whether or not that will stand, but those are the kinds of issues that will predict the costs and the extent of the manpower that are required for our delivery strategy.

Mr. Ted Chudleigh: You also mentioned that the program is ongoing and will step up in the next couple of weeks—and I think you said if the serum's available. Is there some question as to the availability? Now that the program has rolled out, is there still some question about the availability of the—

Dr. Arlene King: Well, we are in real-time communication with GSK, who is our producer in Sainte-Foy, Quebec, and in real-time communication with Health Canada. We know how much we're going to be getting till the end of this week. Now, we understand that GSK is ramping up its production. They are just in the process of ramping up production. Their capacity is about three and a half million doses a week, but they're not there yet. So we will continue to monitor, and that's why I may sound a bit tentative about how quickly we can deliver this

product. But it's all going to be dependent really on how much we get and how fast.

The Chair (Mr. Garfield Dunlop): Thank you very much, Dr. King. Now we go to the third party. Ms. Gélinas.

M^me^ France Gélinas: My first question is, what is your target percentage of people you want vaccinated? If you had it all, how many would you like?

Dr. Arlene King: We'd like at least 75% of the population. Just to give you some context in terms of planning, Ontario has a universal program and we get less than 50% of the population, and in some populations considerably less than that. We believe that 75% is a realistic goal and we've planned for that kind of uptake.

M^me^ France Gélinas: I have full confidence in our public health units to rise up to the challenge and vaccinate 75% of their target area. How confident are you?

Dr. Arlene King: That we'll get 75%?

M^me^ France Gélinas: And that every health unit will rise to the challenge.

Dr. Arlene King: Every health unit in this province will rise to the challenge; I have no doubts about that. The issue is the public perception of risk, both related to the disease and related to the vaccine. That's why we need to be communicating with the public in real-time terms and reinforcing the messages that were asked by the other MPP around safety, as an example, and also communicating whether or not there's any evolving epidemiology, any changes in the virus, any changes in the epidemiologic situation in the province, and continue to remind Ontarians that this disease is present and that the best defence is immunization.

M^me^ France Gélinas: Do you have kind of a backup plan or a plan B? What if those efforts you've just mentioned lead to 50% or 52%, kind of a wide margin from 75% on the low side—way less than 75%? What if we reach 50%, what if we reach 60%? What's your backup plan?

Dr. Arlene King: I think that the initial launch has been quite positive. We've had good public demand so far. We will continue to evaluate our delivery strategies with our health units.

We're sharing best practices already. For instance, one of the medical officers of health has actually developed a script for families with babies under six months, what we say to each and every one of those families with babies under six months to protect them because babies under six months cannot be immunized. So we are encouraging, of course, those who care for and who are around babies under six months to be immunized.

That's the kind of best practice that we're sharing across the province to try to reach those target groups that are most vulnerable right now and we'll continue to do that. Again, we hope that we can get higher than we do with seasonal flu vaccine, and that's going to be dependent on being responsive to some of the communication challenges that are present to us.

The other issue that we're facing, of course, is there's always emerging information, some of which is helpful, some of it is not helpful and some of it is harmful. We have to constantly be evaluating what impact this has and then addressing that in real time. It's not an easy job; it's a full time job, but we're doing our best.

M^me^ France Gélinas: You've talked about being ready to roll out flu centres so that we take some of the pressure off the primary care sector etc. How can the public who sees this—we hear the second wave is here, we hear in the media—whenever there's a case lately, it seems to make the front page. Can you tell me how you measure success? "We will have been successful in addressing the H1N1 if"—and this is where you come in.

Dr. Arlene King: That's a really good question and, of course, we are monitoring our disease rates. There are all these different parameters that we are monitoring. Of course, we will be monitoring our vaccine utilization and uptake rates, monitoring how our health care facilities are coping in real time, determining what our case rates are relative to other parts of the country and other parts of the world. Ontario is doing well so far.

I want to be a little bit anecdotal. I think that during the first wave, with our remote and isolated communities, we were very proactive with getting what they needed to address their concerns, and we had no intensive care unit admissions and no deaths in those communities. We would like, to the degree possible—of course the ultimate outcome is minimizing illness and death as a result of this and I think that's how we'll be comparing ourselves as we go forward, ultimately. It's the population-based impact, so I'm watching that very carefully and that's why we're adjusting our strategies where we can conceivably adjust them to address an evolving situation.

M^me^ France Gélinas: Except for the vaccination rate, which you have set at hopefully 75%, which is a target that you feel your public health units, all 36 of them, are going to give it their best—I feel like you. They'll rise to the challenge and make us proud. Except for that one hard datum, the rest of the way we define success is always moving, and basically will we define success if we do better than Quebec and Manitoba?

Dr. Arlene King: Again, it's hard to know what the comparator is; it's a pandemic. In terms of what disease rates we might expect with a pandemic, we don't know. We will be able to do some modelling after the fact, though, about what we might have expected had we not done what we did. This is always one of the challenges with public health: When you don't have an impact, nobody is too concerned about it. So we will do our best to try to determine what we would have seen had we not mounted the robust response that we had mounted.

M^me^ France Gélinas: But we cannot go out to the public and say that Ontario's chief medical officer of health feels confident that there won't be more than X amount of people infected, there won't be more than X amount of people admitted into hospital, there won't be more than X amount of deaths or other—

Dr. Arlene King: No. In an evolving situation with an evolving virus, I think it would be imprudent and unrealistic to expect that I could do that.

I want to be very clear about the 75%. We've ordered enough vaccine for anyone who wants and needs it, and that is 75% of the population. If we get that, I will be extremely pleased, based on our uptake with seasonal flu. But we felt that was a realistic amount of vaccine to order based on our experience with the universal program here in this province. Frankly, the other jurisdictions were looking to us and said, "When we were trying to make a decision in a context of global shortages of vaccine"—I mean, there are many countries in this world that will be lucky to get any and Canada has enough to immunize everyone who needs and wants it. In trying to make a decision about how much we should order, we felt that a 75% target was a reasonable one. We ordered 19.5 million doses, but that will be adjusted based on the number of doses that we will need to immunize 75% of the population. That will be a downward projection because we're not going to need to give everyone two doses. We're trying, again, to achieve this balance of how much we should keep to protect Canadians and the people of Ontario and how much we let go to make sure other people have an opportunity to be immunized.

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M^me^ France Gélinas: You've talked about the cost of all this. Do we know how much one vaccine costs us?

Dr. Arlene King: Yes. We're paying about $8 a dose for the adjuvanted vaccine. The new, unadjuvanted vaccine that was just approved for use by Health Canada is going to cost us about $12.74 a dose. I think that's what we were told today. It's coming from Australia. I think we will pay about $8 a dose; it might be a little less for the unadjuvanted vaccine that we're getting from GlaxoSmithKline, the additional vaccine for pregnant women. Then, there are delivery costs. The delivery costs, again, vary depending on settings. They're somewhere between $8 and $20, depending on what the setting is. So actually, the cost of the delivery is as much or more than the cost of the vaccine itself.

M^me^ France Gélinas: Okay. You've talked about between $450 million and $650 million. I'm kind of strong in math, and eight times 1.7 million doesn't come anywhere near $450 million or $650 million. What is the rest of the money being planned for?

Dr. Arlene King: This is all part of the overall pandemic response including antivirals and the infrastructure that is required to deliver all of that. I think it might be best if, perhaps, we provide, when we can, a breakdown of what the costs are specifically related to those estimates. They are a little bit of a moving target, as I said, depending on how we're going to have to tailor our response to the outbreak.

M^me^ France Gélinas: Originally we had an estimate for 2009-10 at $752,331,000. The Legislative Assembly just approved an extra $650 million, which we're all under the impression is to help with H1N1. Are we correct in this assumption that, if H1N1 goes away really quickly and we do a really good job of it all, it wouldn't be $650 million, it wouldn't be $450 million? Because $8 or $12 times two million is a long way away from $650 million.

Mr. Ron Sapsford: Yes, the estimate was an "up to." I think, as Dr. King has indicated, there are a number of variables that affect the uptake: two doses versus one. Included in that as well are costs related to the provision of the delivery: syringes and needles; the issues around flu centres that were referred to; in certain communities, if flu centres are set up, then the costs associated with that as well. The estimate was based on all aspects of the campaign, not just the vaccine. Your assumption is correct: If the extent of the outbreak is relatively mild, if there aren't a lot of additional costs in the management of it, then that actual number will drop over a period of time.

M^me^ France Gélinas: Can you share with us what the $650 million was made up of—to request that particular number rather than any other one?

Mr. Ron Sapsford: I see no reason not to.

M^me^ France Gélinas: Okay. I'd appreciate it.

If I have a little bit of time, I would like to talk about public health units. The first one is the Ontario Agency for Health Protection and Promotion. That's fairly new. Is it up and running and how is it going?

Dr. Arlene King: I think it's been going very well. They are forming the backbone of the provision of scientific information to me and to the ministry. We have a scientific response team. They are composed of some agency people but also public health unit staff and other medical experts we bring in, depending on what the subject is. I think it's fair to say they would have liked a little more ramp-up time. They have been, largely, like all of us, dealing with H1N1-related issues. That being said, though, I think this provides us with a lot of learning in terms of the relationship between the Ontario agency and ourselves in terms of the interplay of provision of scientific and technical information in the process of development of public policy.

M^me^ France Gélinas: Whenever I hear we need lots of technical and lots of advice, I kind of hear those little words that say, "And we hire a lot of consultants." Can you give us a breakdown as to how many consultants have been hired by the Ontario agency for public health versus staff being brought in to give you and all of us that advice?

Dr. Arlene King: I can't say definitively that the agency has not hired any consultants, but I will tell you that as far as I know, the advice is coming from agency staff, others from the public health field, and then medical staff who are within the community as well who are contributing to the scientific response. Again, I can't claim definitively that the Ontario agency is not hiring any consultants, but the folks I'm interplaying with are people who work for the agency or with the health units, and they are providing generously of their time to provide me with the best scientific advice I can get so that we can make good public policy decisions.

M^me^ France Gélinas: Okay. Maybe, Mr. Sapsford, you could look into that and give me a breakdown as to—

Mr. Ron Sapsford: I'll endeavour to do that, yes.

M^me^ France Gélinas: Okay. Thank you.

One picky question here: The government has frozen funding for the Healthy Babies, Healthy Children mandatory program for two years. I just wanted to know, did that result in any layoffs in the health units, specifically in nursing, and how is this program meeting demand?

Dr. Arlene King: I don't know the answer to that, but it's something that I think we can probably get. I'm afraid I just don't know the answer.

Hon. Deborah Matthews: It's in a different ministry.

M^me^ France Gélinas: It's in a different ministry? Okay. You're responsible for the public health units, though?

Dr. Arlene King: I, as the chief medical officer of health, work with and provide leadership to medical officers of health in this province. I work closely with the Ministry of Health Promotion, and I have a reporting relationship to the Deputy Minister of Health Promotion as well. So we work closely. I also have an associate medical officer of health who works exclusively with the Ministry of Health Promotion, yes.

M^me^ France Gélinas: Okay. Then you may not be the right person to ask this next question, and if you're not, just let me know and I'll ask later on. I want to know about Panorama, the electronic—let me get the right terms. You know what I'm talking about?

Mr. Ron Sapsford: Yes, certainly.

M^me^ France Gélinas: Okay. The complaints we get from the field are really that Panorama has a hard time connecting with anybody outside of the public health unit; that is, if a primary care agency sends a lab test that can only be done with the health unit, they cannot get those tests back out. Has anything been done to remedy this issue?

Mr. Ron Sapsford: Well, Panorama is not yet up and running in all health units, so the preliminary was a system called IPHIS. I forget the name of it.

M^me^ France Gélinas: Yes.

Mr. Ron Sapsford: I think the comment you're making is probably with respect to that. Panorama is the new program which also extends the application of it to include immunization management, which IPHIS does not do. IPHIS is focused mostly on disease surveillance. So the management of vaccine inventory, response during a pandemic and immunization records are the new pieces of the puzzle that are being added.

It's not up and running yet. The intention is that it would be integrated, however. The importance of information from Panorama being delivered through the electronic health record to physicians as they are doing their primary care is an important concept. So the problems—well, not problems. IPHIS was never designed to do all those things. But certainly the approach or the thinking with Panorama is that it will address that in the future.

M^me^ France Gélinas: If Panorama is not operating in all 36 health units, does that mean that the H1N1 vaccine is not being tracked by that?

Mr. Ron Sapsford: There is an adjustment being made to allow the tracking as we're going through the second wave, but that's in relation to the existing program as opposed to the Panorama implementation. So we've had to be very careful. I think the advice from medical officers is that we need a better way to track the immunization records, and that piece of software is being put into place now.

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The Chair (Mr. Garfield Dunlop): There's time for another question, Ms. Gélinas. There are two minutes left in this round.

M^me^ France Gélinas: I have many more, but I'll stick with Panorama for now. How many health units have Panorama operating, and are you telling me that once Panorama is there, it will be compatible with some of the existing electronic health records within our primary care providers?

Mr. Ron Sapsford: That's the goal, yes. Panorama is still in the development stage. It may be in one or two health units for testing—

M^me^ France Gélinas: Oh, that's all?

Mr. Ron Sapsford: Yes. The implementation was not expected until 2010. Because we're in the midst of a second wave, there was a decision taken that we needed to make some efforts to create software as an extension of IPHIS—it's the best way that I can describe it to you—that would allow for the tracking of individuals who are immunized. When Panorama is implemented, though, it's being designed from the perspective of being integrated into the broader electronic health record process.

M^me^ France Gélinas: Okay. Thank you, and good luck to you, Dr. King.

Dr. Arlene King: Thank you.

The Chair (Mr. Garfield Dunlop): Thank you very much to the third party. We'll now move over to the government members. You have 20 minutes for questions.

Mr. Jim Brownell: Certainly as a government member, I welcome you to the committee this afternoon. As you expressed all the views and comments on H1N1 here this afternoon, I thought to myself, "I wouldn't want your job for all the tea in China." But I want to commend and compliment you on the good work that you're doing.

Mrs. Elliott and Ms. Gélinas talked about the communications and the media and whatnot. I had two questions. One relates to the media confusion that has taken place in the last little while, as we get to the situation that we're into a pandemic. I'd like you to spend a little more time telling us what the government has done to communicate and why they've landed on those communication methods and methodology for doing that.

People in my riding, for example—I come from Cornwall, and I've heard people there say that they have read two different newspapers and gotten conflicting reports on a certain aspect of the pandemic. Could you

give us a little more detail on the communications part of this as you expressed it to the province?

Dr. Arlene King: Thank you very much for the question. The initial priming of the population was brochures that were delivered to every household to talk about H1N1 flu and why it was going to be a different flu season. The next major communications strategy related to the sequencing of our seasonal and our H1N1 immunization programs. Again, for complete clarity, in October we started delivering vaccine to people over 65 and people in long-term-care facilities. We expected and planned for moving into our H1N1 immunization program in November and then finishing up with our seasonal campaign. That information was disseminated, again, to every household.

Right now, I am in the process of doing a lot of recording of radio and TV spots to promote immunization, particularly now that we're in the H1N1 phase. There are newspaper advertisements going into place to encourage people to receive the flu shot and to try to address some of the myths that people might have around the flu vaccine.

Those are examples of some of the concrete bits. We are doing planned media events at least once a week. This week there have been more, depending on the evolving situation. I did one earlier today with Toronto Public Health to address the concerns related to recent deaths in young people in the province. So it's a combination of planned proactive and reactive.

I am the primary spokesperson for the government, and of course we work hard to talk to the other scientists who are out there providing comment as well, because we don't want to confuse the population right now. Scientists and physicians sometimes are a little hard to rein in in terms of trying to get common messaging on issues, but I think everyone is understanding the importance of trying to provide common messaging, so these are some of the strategies that we are engaging in.

I don't know, Kevin, if there's anything else that is worthy of mention, but those are some of the key elements of our communications strategy. Kevin can elaborate. He's the director of communications here in the ministry.

Mr. Kevin Finnerty: Yes, I'm Kevin Finnerty. I'm the executive director of the communications and information branch.

As Dr. King said, our advertising began in the spring with print, radio and online, with preventive messages for the Ontario population on all the basic things they need to do to prevent H1N1. That was then followed up in the beginning of September when we did send a householder to every house in Ontario. We also had several weeks of television advertising that accompanied that householder. We've talked about federal-provincial-territorial cooperation. That television ad was shared with the federal government and was then broadcast across the country for another four weeks. It's now being used on all the airlines across the country. So that has worked very well.

We just, over the weekend, launched another $3-million campaign which has print advertising, radio and online, as Dr. King said; it features her quite prominently. Really, the message of that advertising is: "Go to our website to find out where to get the vaccine"; you can also find information on the vaccine itself and the safety information and the positive impacts it can have in terms of getting the vaccine for your health. We will then follow that up with television advertising later on in November, which will be a very strong push to get people to go to our website and to find out where they can get information on the vaccine availability in their local community.

So we do acknowledge there has been a lot of information in the media. Our challenge is to drive our message out consistently. We've done it at the provincial level and have great co-operation at the federal level as well to do that.

Mr. Jim Brownell: Okay; good. I'd like to switch now to wind farms. I, too, have a question. I'm just wondering, Dr. King, if you could confirm that the ministry did a literature review and found no scientific evidence to demonstrate a causal association between turbine noise and adverse health effects.

Dr. Arlene King: Yes, in terms of the existing literature right now, we have not found an association between adverse health effects and wind turbines. We're continuing, again, to review that information, as I said earlier, and determine where there may be any gaps in the literature that exist in order to be able to develop a common view among myself and all of my medical officer of health colleagues across our province.

Mr. Jim Brownell: Thank you.

The Chair (Mr. Garfield Dunlop): Mr. Ramal?

Mr. Khalil Ramal: Thank you, Dr. King, for coming forward to address our committee and also answer our questions.

I was talking earlier with my office in London, and one of my staff asked me if I'm going to take the vaccine. She's pregnant; she's worried about it; she's concerned. Can you tell her if you advise pregnant females across the province of Ontario—or people with certain medical issues shouldn't take that vaccine?

Dr. Arlene King: Pregnant women are in our first tranche of those to whom we are offering the vaccine because they are at high risk of complications. Pregnant women should all be immunized. Right now, we are recommending, with the adjuvanted vaccine, that any pregnant women over 20 weeks gestation and any pregnant women—period—with any kind of pre-existing health condition speak to their provider about receiving the currently available adjuvanted vaccine, and that women who are under 20 weeks gestation who are completely well receive the unadjuvanted vaccine that will be available next week. That is not to say that they cannot receive the adjuvanted vaccine. The vaccine is licensed for everybody, including all pregnant women, but because there is really very little safety data in pregnant women, particularly in the early part of pregnancy, we

would suggest that the unadjuvanted vaccine would be preferred. We now know we are getting that early next week. So that is the advice we are giving to pregnant women.

Mr. Khalil Ramal: Okay. I heard some advertisement asking every person across the province of Ontario to take the vaccine. If a person feels well, excellent, in good health, in good shape, why, in your opinion, do they have to take it?

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Dr. Arlene King: Everyone should be immunized against the flu to protect themselves, to protect those around them and to protect their communities. It's absolutely critical, and we are strongly recommending that everyone in the group that we're offering vaccine to this week get it. We are also recommending that, when we roll out the general program, everyone be immunized. It is absolutely critical. It is the best and it is the safest way of protecting yourself against the flu.

The Chair (Mr. Garfield Dunlop): Mr. Delaney.

Mr. Bob Delaney: I'd like to ask about the H1N1 vaccine and the seasonal flu vaccine. People have asked me about taking the two of them, and I've said that everything I've read says that you should get both vaccinations. Can you tell me a little bit about whether or not there's any recommended time between taking one and taking the other, whether there are any peculiarities between individual groups, be they young, pregnant women, seniors? Could you talk to me a little bit about synchronizing it so that people get the maximum benefit? If there any instances of who shouldn't take both shots, what would they be?

Dr. Arlene King: We just finished reviewing all of the science, and the statement on the use of the H1N1 vaccine has just been published. The statement from a national level on the seasonal flu, if it's not up, it will be imminently. Both vaccines can be administered at the same time. If they aren't administered at the same time, we are not changing the delivery of our programs to be able to do that. We feel that logistically it is best that we concentrate right now on our H1N1 program, but both vaccines can be given at once. For those people, for instance, who are going south for the winter, they can receive both vaccines at the same time. Those who are travelling to the Hajj—I'm giving you some examples—require both seasonal and H1N1 vaccine, and can receive vaccine at the same time. There is no minimum interval between the two vaccines; one could receive H1N1 vaccine and conceivably receive seasonal flu vaccine tomorrow.

That all being said, we do have a program delivery strategy that I've outlined, which is, right now, people over 65 and people residing in long-term-care facilities. Also right now, because we've moved up our H1N1 program by a week, the H1N1 program going back to seasonal, we're trying to consider three issues as we roll out our program. One is the logistical issues of dealing with a complex vaccine. The second is, what's the threat of the day? It's H1N1; 99% of our viruses right now are H1N1. We are seeing almost no seasonal flu; that's why the decision to delay the seasonal flu vaccine administration. Those are really the primary considerations at this point in time.

Mr. Bob Delaney: When typically do you see the peak of instances of the seasonal flu?

Dr. Arlene King: When?

Mr. Bob Delaney: At what point during the year, or does it matter or vary?

Dr. Arlene King: This is a pandemic, and we don't know when and if we are going to see seasonal flu. There has been a little bit, a few detections of seasonal flu viruses. In much of the world, though, when the pandemic virus has moved in, it has completely displaced the seasonal flu viruses. When we start seeing seasonal flu again is really anyone's guess. I will tell you, though, that, interestingly, China is seeing a mix of both right now, but most other parts of the world are seeing, pretty well predominantly, the H1N1 flu. We don't know why this occurs entirely, why when we have a pandemic, and this has been seen in previous pandemics, that virus displaces the other seasonal viruses. But we need to be prepared to continue with implementation of our seasonal flu program.

We're not stationary creatures as well. People in this province move around a lot, and we don't know what bugs are necessarily circulating in the place where they're going as well. So we're offering both programs in the best way possible.

Mr. Bob Delaney: Okay, that actually is very helpful. A lot of what I had been reading about a month ago came from US sources, and some of the things that you're saying are making it unique to Ontario.

When people are speaking with me and they say, "Well, I'm just going to get the H1N1," I should be encouraging them to, "Get your H1N1 and also get your seasonal flu shot, and it doesn't really matter what order you get them in; it doesn't matter whether you're getting them at the same time." What I have been telling people is that my understanding is that when they closed off what the specs were for the seasonal flu vaccine earlier this year, they hadn't yet isolated the elements of the H1N1 virus and as such, it wasn't incorporated in the seasonal flu vaccine, and the seasonal flu vaccine as a result doesn't inoculate you against H1N1. Are my assumptions correct so far?

Dr. Arlene King: That's absolutely correct. The decisions on what goes into the seasonal flu vaccine are made in February at the WHO and the recommendations are given to manufacturers in February. This virus didn't emerge until mid-April, unfortunately, so there wasn't an opportunity to include the H1N1 killed virus into the seasonal flu shot, and that's why we're administering two.

Stay tuned: My guess would be that next flu season, this H1N1 virus will be incorporated into the seasonal flu vaccine.

Mr. Bob Delaney: I'm actually very interested in this because one of my constituents is Hoffmann-La Roche, whom I gather make the H1N1 vaccine. Is that correct?

Dr. Arlene King: No. Hoffmann-La Roche makes Tamiflu and GlaxoSmithKline makes our vaccine in this country.

Mr. Bob Delaney: That's fine, they're constituents too. Not for nothing do they call the riding of Mississauga pill hill.

Does anybody else have any other questions? Chair, I think the government rests its case.

The Acting Chair (Mr. John O'Toole): I'd like to thank the chief medical officer of health for Ontario. It was very informative and educational. Keep up the good work educating the public.

With that, we're going to resume the rotation with Madame Gélinas. You have 10 minutes for your first question.

M^me^ France Gélinas: I think I had about 10 minutes left in my opening line of questions that were not focused, so I will continue to be all over the front page of the paper. I think my last question had to do with contracts paid to a consultant within the Ministry of Health, and you had agreed to look through and bring back some figures so that we have an idea.

My next line has to do with how much of the $40 billion-plus actually makes its way to people delivering hands-on care versus how much of it is used for leadership, governance and other activities. I understand that with the LHINs, the Ministry of Health is now the steward and your role is to set the broad policy; the LHINs are there to really plan at the local level. Since we've had the LHINs, has the amount of money that is spent at the Ministry of Health changed, as in within the civil service, and where does it sit at right now?

Mr. Ron Sapsford: When local health integration networks were put into place, the business case, if you will, that was made around them was that the increases in local health integration network staff would be offset by reductions in staffing that came from the closure of district health councils. If you remember back, we had district health councils across the province. Given that part of the role of local health integration networks is planning at the local level, those numbers were incorporated. Then on top of that, there was the agreement to close the regional offices of the Ministry of Health, which also played a local role with providers. So between all those changes, there was a full offset in total staffing that saw the creation of local health integration networks.

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To the question about—

M^me^ France Gélinas: Did you track the money? Could you tell me, in the last year of operation of the DHCs, how much they cost in the last year of full operation of the district offices? Can we see the savings someplace at the Ministry of Health level? I guess you could give me also how much we spent on the LHINs this year.

Mr. Ron Sapsford: Bearing in mind that we're going back to 2006 to look at costs, I suppose we could do that. But what I'm trying to say to you is that in terms of staff numbers, there were full offsets from the creation of LHINs and the closure of both ministry programs and services, as well as district health councils. I don't think we've done an actual direct comparison after that fact.

M^me^ France Gélinas: Okay. Also, some of the planning activities that used to be done at the ministry are not supposed to be done at the ministry anymore with your new stewardship role; they're supposed to be done at the LHIN level. Wouldn't that mean there would be savings with the civil service that works for the Ministry of Health, given that you don't have those tasks anymore, but we do have separate structures with those responsibilities, and I'm guessing the budget to pay for them?

Mr. Ron Sapsford: Yes, that's right. The implementation of local health integration networks dealt with the local related issues and local planning issues, as you've said. But part of this change as well is about changes in the Ministry of Health itself. As the decision-making was delegated to local health integration networks about more current operational, where the ministry changed its focus was to look at longer-term policy options and creating a much better skill base in the ministry for things like funding models and allocation mechanisms, shifting from our current formulation of funding to looking at other practices.

It's not simply that the ministry stopped doing it; there was also recognition that there were some functions that the ministry had to increase in strength. So rather than a total offset, we've redirected some ministry resources to those new functions, and that was also part of the change in the model and role of the ministry. It's part of the stewardship model, as well.

M^me^ France Gélinas: Okay. Let me rephrase it, then. This new model with LHINs, with the new responsibility at the Ministry of Health—how I can see how much or less this model costs us is what I'm interested in. I'm interested in knowing if we now spend more on the planning, the stewardship than we did before we had the LHIN structure—and did we track that? Am I the only one interested in this?

Mr. Ron Sapsford: No, you're not. But you're asking me to do a zero-sum calculation. What I'm trying to indicate is, when they were created, the staffing offset, which is a direct indication of the costs associated with it, was netted out. I'm confident to say that the resources at that point in time—the case was made that there was an offset from the changes I've made.

Your question is, then, is it the same today? And I'd have to say no, it isn't, because from that point forward there had been other changes, other demands and other thinking about the role of the ministry and the role of LHINs.

We could go back in time and show the increments, and the estimates will show year over year where ministry expenditures have increased and where LHIN expenditures have increased. That information is contained in the estimates. But a calculation forward in time from 2006, when they were implemented, has not been made.

M^me^ France Gélinas: And I would say that when the district health councils closed and the LHINs were first

created and the regional offices eventually closed, the number of staff, for the ones that I know, anyway, was pretty much equal. Now the LHINs have grown to be way bigger than what district health councils ever were—the ones that I deal with, anyway. Although it is an estimate, I have not been able to follow this money through to see the difference. I'm interested in the new model. Does that mean we spend potentially more on the civil service and the planning facilities at the LHINs and the ministry versus what can be transferred to transfer payment agencies that provide care?

Mr. Ron Sapsford: The question about transfer payment versus administrative overhead, year over year over year, is weighted toward providing service to people. Our administrative overheads are kept to a minimum. The challenge for the ministry every year is to absorb as much cost as possible into our existing expenditures. So you will not see increases in ministry staff advancing at the rate that the transfer payment increases. That's very clear.

The question you raised about numbers of staff—in the district health councils, I think we had 26, if I think back, and in LHINs we have 14. You said more staff per LHIN, and that's probably true, but if you look at the overall numbers, you would see, between the staff the ministry used to have and the DHC staff, that much of the allocation to LHINs was based on those numbers. In total, there was not a large increase in the number of staff in LHINs.

The Acting Chair (Mr. John O'Toole): Less than one minute.

M^me^ France Gélinas: My, that goes by fast. My last question was about eHealth. The question is simple. I want to put eHealth behind, but I still want an electronic health record. How long before we can have a new target date for an electronic health record? If you have the date, share it. If you don't, what's the process to get a new date?

Mr. Ron Sapsford: The current strategy is that between 2009 and 2012 is the first phase of that. The strategy focuses on diabetes as the population around which the electronic health record will be designed. In order to do that appropriately, one needs to integrate drug system information, laboratory information as well as other clinical information. The strategy is to implement that first and the components associated with it, and then, post-2012—or perhaps before—begin to broaden the application to broader groups in the population until ultimately the whole population is—

The Acting Chair (Mr. John O'Toole): Thank you very much. I'm sure the minister can conclude. Thank you, Ms. Gélinas.

Minister, you have up to 30 minutes to use as you wish.

Hon. Deborah Matthews: Thank you very much. I appreciate it.

Let me just add to the last question for a moment. I don't think we'll ever get to the point where we're done eHealth because, as technology improves, we will always be trying to enhance what it is we do. I wanted to make that comment.

What I wanted to spend my 30 minutes on is—I'm going to do something a little bit different. I want to talk about the transparency in our health care system in Ontario now. I want to also talk about an issue that came up a little bit earlier about how we measure our progress. How do we know things are getting better, or not better? How do we measure it and how do we communicate that to people? Earlier, we talked about how you can't really measure improvement by how much more money you spend. We actually want to see tangible results.

If you could turn your attention to one of the screens—I would have preferred to do this, actually, using the Internet, but what we've got are some screen shots that will demonstrate the information that is available to the public and the province.

Part of our eHealth strategy is better availability of information. Our approach in health care has been that we need to set clear targets. We need to measure our progress and we need to really drive home the results to know how far we've come and where we need to do better.

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The public can go to a website—it's ontario.ca/health—and they will come up to a screen like that. The first item I want to really talk about is patient safety. This is an issue that came up earlier today.

I can tell you that Ontario was recognized as a leader in patient safety. We publicly report more patient safety indicators than any other jurisdiction in North America. As a leader, we've worked with experts in the field of infection, prevention and control to define what measures to report and identify what supports are needed to help hospitals lower their rates of infection and provide safer care.

I know you can't see this very clearly. I see some of you have laptops. Maybe you can follow this on your laptop. We have developed a three-pronged strategy for public reporting, creating a public health agency that gives us expert advice on patient safety and then spreading those best practices and creating resources to help hospitals lower infection rates and manage outbreaks.

When a member of the public goes to our website and clicks "patient safety"—I will follow along on my slides here—they will come to a screen that looks like that, that lists the hospital infections that we track. We started tracking C. difficile in September 2008 by hospital. Starting December 2008, three others—MRSA, VRE and HSMR; I am not going to try to say the names of those, other than the initials—and, coming in April 2009, four other indicators that we track—each hospital and public report; in April 2009, central line primary bloodstream infection, ventilator-associated pneumonia, surgical site infection prevention and hand hygiene compliance.

Anyone in the public anywhere in the world can actually click one of those, so let's look at C. diff. and see what we come to. People would get the screen that describes C. difficile and it gives them some options on

where they want to go so they can learn more about C. difficile. They can learn about how to reduce the rates. They can also look at the rate of infection in any hospital that they're interested in seeing. If they were to click the link to rates of infection in Ontario hospitals, they come to this screen which allows them four different ways to find the information they're looking for.

Let's just assume that someone was looking for Scarborough General Hospital. They click the location name, they come up with a list of hospitals and they find the hospital that they're searching for. If they were to click "Scarborough General Hospital," they'd come to a screen that shows all of those infections, what the rate is. In C. difficile, it's the rate per 1,000 patient days: 0.12. They had fewer than five cases. You can also see the rates of the various other—what do we call them? Infections?—indicators that I've mentioned that those hospitals are now reporting on. Then we can let people compare.

What does this mean? How is Scarborough General doing compared to other hospitals? If you click, "compare with similar hospitals," you come to a screen that shows you all of the hospitals in Ontario that are comparable and it shows their rates. What you would see on this site is that Scarborough General is actually doing very well relative to other hospitals.

Now, from that screen, if you go to the "trend" button, you actually see—and again, I apologize that you can't really see it as well I as I had hoped you would on these screens, but what you see is the time series of how this particular hospital has done compared to itself and compared to the provincial average.

I can tell you that this hospital is one that really shows that with the right interventions, a hospital really can change their rates of C. difficile. It had one of the worst—in fact, I think it had the worst rate in the province one year ago, but the work of the supervisor, Rob Devitt, and the hospital's management to improve the overall functioning of the hospital has now made it one of the best performers in the province. But as I say, any member of the public can get that information and they can compare it with other hospitals.

That's just an example of transparency. It's an example of how we measure and publicly report and how we actually can drive change. You'll be interested to know that public reporting in and of itself actually improves rates of things like C. difficile in the hospital because every hospital, once it's publicly reported, wants to do as well as it possibly can.

I want to move now to something else that again publicly shows how we're doing. Now we're at the Ontario wait times page. When you get to the Ontario wait times page, you've got a choice: You can either look at emergency room wait times—you heard me say earlier that reducing wait times in emergency rooms is a very high priority for this government—

Mr. Khalil Ramal: Especially in London.

Hon. Deborah Matthews: Especially in London, but across the province. We also have established wait times with provincial standards for a number of different surgeries and diagnostic imaging.

Let's just pretend that we're looking for wait times for general surgery. If we were to click surgery and diagnostic imaging, then we come to the page that allows people to choose from some choices. Wait times in their area: If that's what they're looking for, they click on that. Then they're led through a series of pages: What kind of a procedure are they looking for? Where do they live? What hospital are they looking for?

We're going to just look at the Waterloo Wellington LHIN and see what is happening there. You come to that page. Those are all the hospitals in that LHIN. We're looking at general surgery. We see that our provincial target is that 90% of people who need general surgery wait less than 182 days. That is our provincial target; that was a provincial target that was established by experts who really looked at the question, "At what point does somebody's condition actually get worse?" And 182 days was that point at which the experts said, "For medical reasons, you really want to have people through that surgery within 182 days." You can see again, by hospital, what those general surgeries and wait times are and what the average is over the LHIN. So in the Waterloo Wellington LHIN, the average is 89 days. That is a significant reduction in wait times over the past several years and significantly below the 182 days that is determined to be medically necessary.

I want to just pause for a moment and talk about some of the successes that we've had when it comes to wait times. There's a national organization called the Wait Time Alliance. Ontario was recently given straight As for reducing wait times for hip and knee replacements, cancer, cataract and cardiac surgery. Ontario was the only province to score straight As. I think that really is an indication of how effective we have been in bringing down wait times.

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Cataract surgery is where we have seen the greatest success. Our baseline was 311 days that people waited for cataract surgery. That was in September 2005. We have now reduced that to 108 days, so that's a reduction of over 200 days that people are waiting for cataract surgery. I'm sure we all know people who are waiting for cataract surgery, who have waited, and the difference that surgery makes in the quality of life for people is enormous. They can read again, they can drive again, they can go back to work again in some cases. So we've reduced, as I say, cataract surgery wait times by 65% since we implemented our wait time strategy.

When it comes to knee replacements, and I know there are some people in this room who know first-hand what it feels like to wait for that kind of surgery, the wait time was 440 days. That was our baseline wait time for knee replacement surgery; the baseline, again, September 2005. We've been able to take 265 days off that wait time: 265 fewer days of being in pain, of having your activities limited. We've taken it from 440 days to 175 days. What we're looking for, the target, is 182 days, so

we have now reached that target and are slightly below that target.

Hip replacement again: Wait times decreased by 56%, from 351 days—so that's a year—to 152 days. That's a reduction of over 115 days.

So if you really think about what difference we have made for people in the province, Ontarians have spent 73 million fewer days waiting for procedures. That's 178,000 years, or, if you wanted to, 2,400 lifetimes, less spent waiting for surgery.

What this shows is that we really can make a difference if the government of the day decides that we're going to make a difference, they have the right strategies, they publicly report. I think this is something that all of us in Ontario should really take pride in. We are, as I say, leading the country when it comes to this, and it's transparent. Anybody can see what the wait times are in their community, in their region and across the province.

Then, if people want to know where the shortest wait times are in the province, they can, with the click of a mouse, see where the shortest wait times are. Again, for general surgery, if you click "shortest wait times," you'll see Renfrew Victoria Hospital: 31 days. That's significantly less than the provincial target of 182. You can see where the shortest wait times are. What this information does, of course, is allow us to make the strategic investments that are really important to continue improving the wait times.

Now, I will tell you that we still have challenges when it comes to MRI and CT, but we have made remarkable progress over a short period of time in bringing down those wait times.

Another feature of this website is that you can see over time what has happened. So what I just went through are the current wait times for various procedures in various hospitals. It also allows you to see historically how we have done. Again, it's the time series of that procedure for each hospital.

I think I'll move now to the emergency room wait times. As you've heard said over and over again, emergency room wait times are a very high priority for this government. I can tell you that the emergency room wait time is much more difficult to improve on because the emergency room is the place of last resort for people who don't have access to family care. It's a situation that's exacerbated by lack of home care or beds in long-term care. When we decided to take on emergency department wait times, we knew that we were taking on a very big challenge. But again, it's a challenge that we are proud to take on and it's a challenge that, I can tell you, has been embraced by the broader health care sector. Everyone knows that we need to do better when it comes to emergency room wait times.

Again, if you click on that emergency room wait time, you can see, with the click of a mouse, the time spent in the emergency room in your area. This page also offers other options. Some people don't really need to go to an emergency department. If they knew where to go for other kinds of medical help, they would go there. So again, with the click of a button, they can see what other health care options there are for them in their own neighbourhood. We can go to the location. We went to the location of Sudbury; we just chose that place. You can type in the area that you want to go to, and then that takes us to the hospitals in Sudbury.

We have set our targets; these are ambitious but achievable. With the less complex cases, we want people to be in and out of the emergency department within four hours. With the more complicated cases, we want people to be in and out within eight hours. Emergency room wait times are measured not on how long you have to wait to see a physician, but on how long you spend there, so from the time you come in and get registered to the time you can actually leave the hospital or are admitted to the hospital.

What we see in Sudbury, for example, is that our target is eight hours. The Sudbury Regional Hospital, St. Joe's Health Centre, is at 12.9; the provincial average is 12.8. This is a new strategy. We're starting to work to bring those numbers down, and we're showing some success. For the less complicated cases, province-wide, we're at 4.8 hours; in Sudbury Regional Hospital, 4.2 hours is where they are now.

The point of this presentation really is to show you that when we talk about transparency, we're walking the talk. When we talk about measuring results, we're measuring and we're reporting publicly. I have to tell you that this, for me, is an extraordinary advancement when it comes to health care, because when people understand their health care system better, they'll have more confidence in it. When they see the difference that investment decisions can make, they will be encouraging government to actually make those changes.

How much time, Chair, do I have left?

The Acting Chair (Mr. John O'Toole): There's exactly nine minutes left.

Hon. Deborah Matthews: I have exactly nine minutes. I think I probably have covered what I wanted to cover on this. I know that members do have questions, and I'd be happy to just move to the questions. Thank you.

The Acting Chair (Mr. John O'Toole): Thank you very much, Minister. With that, we'll move to the official opposition. You have 20 minutes. I'll recognize Mr. Chudleigh.

Mr. Ted Chudleigh: I'd like to ask the minister about the hospital in Milton. Milton was beginning the process of building a new hospital in 2001. When the government changed in 2003, that process came to an end. It started up again in 2007 with a business plan to determine whether or not Milton needed a hospital. In 2001 it had already been determined that Milton needed a new hospital.

Your Places to Grow has seen Milton's population grow from about 30,000 in the mid-1980s, where it stayed until the late 1990s. Today, that population of Milton is at 90,000 people, three times more than when the hospital was built; the hospital was built to accom-

modate about 30,000 people. We're currently at 90,000 people. In 2021, we'll be at 140,000 people.

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Of course, when you shut down the Oak Ridges moraine as a building site for new houses, that demand had to go somewhere. Milton had the land, and a lot of that growth was forced into Milton, making for very rapid growth.

As I said, in 2007 the business plan started up again. It was approved. However, the next phase of the process of building a new hospital has not begun. Milton is undergoing some very severe wait times and service problems. The hospital has submitted what they refer to as a coping strategy to get them over the hump as to the wait time that will be required to get to the new hospital, which couldn't be completed until 2014.

Things like obstetrics are creating huge problems. We had 350 babies a year in 2001-02; we were looking at 1,100 babies last year. That's about what the hospital can handle. They're probably on track for about 1,400 babies born in Milton this year, with a significant number of them being shipped to other hospitals as far away as Hamilton and Toronto because the surrounding hospitals—Burlington, Oakville, Georgetown and even the Credit Valley Hospital—are also experiencing crunch times. The wait times in those hospitals are very long.

Minister, we expected some kind of an answer this fall. We hear through the grapevine, because communications aren't very good, that we are probably looking at next spring before we get any kind of a decision, and that decision could be yes or no as to the expansion. We're not assuming it's a yes, but not knowing until next spring makes the wait time extremely frustrating for the people of Milton.

Minister, how long is this going to continue? What can you tell us about how you feel about the people of Milton being disenfranchised in the health care system of Ontario?

Hon. Deborah Matthews: Thank you. I think what you have spoken about demonstrates how important hospitals are to communities and how important adequate hospitals are.

It's because of that need for that infrastructure that we committed $30 billion to our ReNew Ontario fund. Of that, $5 billion has been allocated to capital projects. I think there are more than 100 hospital projects happening across the province right now.

I cannot speak specifically to the Milton hospital. What I can tell you is that I will get an update for you. I don't know if my deputy has any information on that specific project—

Mr. Ted Chudleigh: I can indicate to you, Minister, that of those 100 construction sites in Ontario, there is no site that is growing at a faster rate than Milton. Milton is the fastest-growing town in Canada. It is the fastest-growing town of its size in the world—and that includes China, where the growth rates are exponential. The people of Milton are beginning to suffer. Every week I get more and more concerns expressed.

Now, let me say that the hospital and nursing staff at Milton are coping extremely well. Once you get in the hospital, the care that you get is very good. But it's getting in the hospital: The wait times for emergency etc. are really extreme.

The fact that this growth, that this concern for the hospital has been exacerbated, if not caused, by the Liberal government's Places to Grow legislation makes it doubly frustrating. The municipality had to supply roads and had to supply recreational facilities, all kinds of things, all of which has been supplied on time as needed. The school boards had to supply schools as the growth in these communities took place. They've all been supplied pretty much on time. There might have been some six-month delays. There have even been some that have been six months early, schools that have sat empty for six months, but they've all been done on time. Even the 401 has been expanded in certain places to ease the crunch of the flow.

The only thing that has not kept pace in Milton is the expansion of the hospital, which started in 2001, was stopped with the change in government and wasn't restarted again until 2007, something that you well knew was going to be a significant problem for the people of Milton. So I would look forward to your update, unless the deputy has something further to add.

Mr. Ron Sapsford: My only comment would be about the part of the question about time frame. We are now entering, of course, preparation for our next fiscal year and so additional approvals to the capital plan would fall into that particular process and not be approved until the conclusion, which would take us into the next fiscal year.

Mr. Ted Chudleigh: So you're suggesting that next spring is not just a rumour; it's probably when we will hear as to what will happen for the Milton hospital?

Mr. Ron Sapsford: That's the process that we're in now, yes.

Mr. Ted Chudleigh: And there's no way to fast-track that decision, given the situation that Milton faces?

Hon. Deborah Matthews: I'm a bit confused by your—what happened in 2007? You say—

Mr. Ted Chudleigh: The process restarted in 2007 with a business plan. For the process to expand a hospital, you have to start with a business plan that says, "Do we need a new hospital?" Basically, they updated the statistics that were gathered in 2001 and submitted to the government within the six-month time frame that they had. That program took about $1.2 million that was supplied by the provincial government for that study. It came in on time, under budget, because it was a very simple study of updating the previous information.

The second stage is to design the hospital as to what that hospital's going to look like, what facilities are you going to need, what are the obstetrics facilities, what are the operating facilities, how many beds are you likely to have, given the demographics of the area. That study has not been approved nor moved forward by the provincial government, even though the need is so obvious that it's

confusing to everyone in town, everyone involved with the process, as to why it hasn't moved forward.

Hon. Deborah Matthews: As I said, we do have 100 projects, more than that that are under way—

Mr. Ted Chudleigh: And none of them in a town that is growing as fast as Milton.

Hon. Deborah Matthews: I hear your advocacy. I admire that, and I will find you information on the hospital in your particular community.

Mr. Ted Chudleigh: And what kind of time frame would I expect on that?

Hon. Deborah Matthews: I'll get you an update as quickly as I can get it.

Mr. Ted Chudleigh: Thank you, Minister.

The Acting Chair (Mr. John O'Toole): There are about 10 minutes left for your side.

Mr. Ted Chudleigh: Let's talk about Oakville. Oakville, as well—it's the same story. Oakville is growing, not as fast as Milton, but it is growing. The new hospital there was started in 2001; it came to a screeching stop in 2003. Interestingly, if that process had continued, Oakville would have had a new hospital today. As it is, the hospital was delayed for about 10 or 11 months in its construction process—the system in Oakville restarted again in 2005.

The time frame for building a new hospital can be eight to nine years; however, there are four or five stages that people go through, the last stage being that of construction. What chews up the time is the wait period between when one phase is submitted and an answer comes back from the Ministry of Health or the Ministry of Energy and Infrastructure, even though the Ministry of Health, particularly in the first stages of development, is working hand in glove with the local hospital facility and so they are fully aware when the report comes in of exactly what that report says.

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They should be in a position to make a decision relatively quickly and astutely on what has been submitted. That is not taking place in the proposed construction of the new Oakville hospital. There are large gaps of time between when projects are submitted and when projects are approved or the next stage of the development takes place. Those large gaps of time are what push the construction phase out further and further, so that the Oakville hospital, which we hoped at one time would be built in 2013—now it looks like 2014, and if the current stage doesn't get an answer pretty quickly, we're going to be looking at 2015.

Incidentally, the current Oakville hospital is at full capacity now, and they are continuing to build houses in Oakville at an alarming rate; not as fast as Milton's, but it is certainly the second-fastest-growing town in Ontario. So we have those two hospital construction projects in juxtaposition to each other, which doesn't allow either hospital to send overflow to the other one.

Burlington is in a situation where they are practically full; they are practically operating at capacity. The growth rate of Burlington is almost grown out. They don't have a lot of construction left and therefore are not growing at the same rate and don't have the pressure on them, but they don't have a lot of excess capacity in that hospital to absorb the overflow. The nearest overflow is in Hamilton; if you phone Hamilton and tell them you're coming, they'll tell you not to come, that you're not in their catchment area, but if you show up at the door, they'll take you. So don't phone; just show up at the door. That's the word around town, and it's amazing: Everyone knows it.

It's a very frustrating situation, and the lack of accurate information that is flowing exacerbates the situation, and, of course, when good, solid information isn't available, rumours take hold. The rumours that are floating around are far worse than no construction at all, ever. It flows right across the system, so it's a very, very difficult situation in both Oakville and Burlington. Credit Valley, as I said, with the exception of cancer care, is at maximum in many of their facilities, so they're unable to help us as well.

Hon. Deborah Matthews: Thank you. While my deputy is looking to see if he has an answer, I'll tell you that I'm particularly interested in Oakville; my daughter lives in Oakville, so—

Mr. Ted Chudleigh: So she's aware of the problems of the hospital in Oakville.

Hon. Deborah Matthews: She hasn't raised that particular issue with me, but I'm sure she will now. So over to my deputy—

Mr. Ted Chudleigh: Again, the hospital, the facilities—the nursing and the doctors are doing a magnificent job, if you get into the hospital. It's getting into the hospital—they go the extra mile. They attempt to solve problems in emergency that need more care than can be handled in emergency, so people are sent home in a situation where perhaps, if the hospital wasn't under so much pressure, they wouldn't be sent home; an arm break that isn't quite properly set, and perhaps if it wasn't under such pressure that wouldn't happen, so the arm comes back the next day for more setting, which is a very painful experience for the patient.

Hon. Deborah Matthews: Let me turn it over to my deputy. You have lots of papers with lots of numbers there—

Mr. Ron Sapsford: No, I'm fine. The question for Oakville is perhaps easier. It's in the process of planning, and I take the point you make about moving from phase to phase; but we will attempt to keep to the schedule that's been developed with IO. Infrastructure Ontario is very good at keeping to time frames, so I'm not concerned about too much drift in the approval schedule.

There are occasions during the negotiation of the project between the hospital and the ministry, mostly around local share; it's usually the financing of it where we have the most problems. I'm not saying that's the case in Oakville, but it's very important before we move to the construction phase or put the RFPs out that the financial obligations of all the parties are very clearly laid out.

I know it's been a characteristic of the planning process in the past, as you've suggested, where a hospital is in a particular position and then waits long periods of time to move to the next phase. What we've done over the last couple of years, since the government announced its capital redevelopment, is to be far more disciplined about who is in the planning phase and to be much more clear that, yes, this hospital is in the formal planning phase, presumably moving from phase to phase in an orderly fashion.

Again, I would add that's based on the fiscal ability of the government to take new projects into the plan and that's a judgment that's placed every year; every year, we go through that re-evaluation. Then, to be clear, with hospitals that do not have approval to enter the planning process for the very reasons you've said, it's an expectation in a community that a hospital is moving forward when, in the short term, there's no realistic expectation that that will take place.

So we've tried to adjust the planning process to be clear with individual hospitals, whether they're in or out of the planning process, and to give some reasonable estimate of time as to when a particular project will be funded.

Mr. Ted Chudleigh: I'm just saying that no hospital in Ontario can make a case that's as strong as Milton's and that it's been waiting over a year now from its initial business case, which it made very strongly, for a response to that in order to move into the next phase, which includes a unique phase called a coping stage, which allows them to get to the next phase.

Mr. Ron Sapsford: And that particular project is in process, yes.

The Acting Chair (Mr. John O'Toole): There's about one minute left, if anyone has a comment. Ms. Elliott?

Mrs. Christine Elliott: In the short time remaining, I would like to just ask a few follow-up questions from some of the issues that I asked you about this morning, Minister. Apparently I left a few loose ends, so I'd like to just make sure, if you'll bear with me, that I ask you this again.

I'd like to have a clear request to you on the record that once a search is performed for any contracts given to McKinsey and Co. for the use of the ministry and paid for through hospital budgets, if any, I would appreciate copies of any contracts or contacts that you find in that respect. I think Mr. Sapsford made a comment about that but I'd just like to have a clear commitment to provide that information, if I might.

Mr. Ron Sapsford: My understanding of your question was the list of the contracts. Yes, we'll do that, certainly.

Mrs. Christine Elliott: Thank you. In addition—this is almost the same follow-up question—I'd like to ask that the same search be performed for any consultants' contracts other than McKinsey and Co. that have been negotiated by the Ministry of Health, where there has been direction to hospitals to pay all or any part of the cost of the consultants' fees—with consulting firms other than McKinsey and Co. I'd like a clear commitment for that search to be conducted and the results to be communicated to us as well, please. Thank you.

The Acting Chair (Mr. John O'Toole): Ms. Gélinas, you have 20 minutes. We're going to say 10 minutes now, and then when we resume, it would be 10 minutes at the opening. All right?

M^me^ France Gélinas: I seem to be on this rotation where—it's okay.

I have agreed for Dr. King to leave because I understand, but some of the questions I have are to do with public health, so if you don't have the answers, I'm quite willing to wait and have them in the briefing book that comes after.

The first one is a question I asked when she was here. The government has frozen funding for Healthy Babies, Healthy Children for the next two years. I wanted to know how that decision came about, what were the decision criteria to do this, and, then, what are the consequences of that decision. I'm particularly interested in the consequences in job loss, wait times or a change in mandate of this program.

Hon. Deborah Matthews: If I could speak to that, I have a little bit of familiarity because that is in the Ministry of Children and Youth Services. If you could direct that question to them, that would be the appropriate way to do it. It's not a Ministry of Health program.

M^me^ France Gélinas: But it's delivered by the health units.

Hon. Deborah Matthews: Yes, but it's not a ministry program.

M^me^ France Gélinas: They get their funding for Healthy Babies, Healthy Children through the Ministry of Children and Youth?

Hon. Deborah Matthews: That's correct.

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M^me^ France Gélinas: So they get their funding for Healthy Babies, Healthy Children through the Ministry of Children and Youth Services?

Hon. Deborah Matthews: That's correct.

M^me^ France Gélinas: Well, there you go. Okay. The next question: Remember the capacity review that released its report in 2006? Are we doing anything with this report, and have any decisions been made regarding restructuring and reform of public health based on this report?

Mr. Ron Sapsford: Yes. There have been a number of follow-ups to that. It was a quite a broad-based report. It covered a lot of different issues, all the way from issues around medical officers of health to governance structures and so forth.

On the pieces dealing with medical officers of health, there have been some significant steps taken in terms of remuneration. It was an issue under discussion between MOHs and the Ontario Medical Association, and there were some provisions made for that in the Ontario Medical Association agreement.

On this same vein, there were issues related to the Ministry of Health, and we took quite major steps in

reviewing and making it more attractive to attract physicians into the Ontario public service in the division. I would suggest proudly that, with Dr. King now on board and the appointment of another associate and some other recruitments, we've started to see some changes there.

On the more formal structural parts of recommendations about reviewing governance structures, I'd have to say no, there has not been forward movement on that.

On the question of the number of health units, which I think was another major part of that recommendation, the government decided that it would be better to move forward with questions around the core standards work and to have that done first, and that work was completed in the past year. New core standards are now being put into place with appropriate follow-up and measures to do that.

There are some outstanding parts of it that have not been formally responded to, but there are other parts of it that have been moved forward quite aggressively.

M^me^ France Gélinas: Is it the intention of this government to move ahead with restructuring health units, the number of health units, in the coming year?

Mr. Ron Sapsford: I can't speak for the government on the point and wouldn't try. I think, though, in the consideration of the issue, one of the key points that was made was structural change because of the difficulties in some parts of the province in gaining medical officer of health leadership. There have been discussions at various health units to look at ways of doing that. Whether one comes to a decision about actually changing the number is a question that really needs to be discussed between the ministry and the municipalities that are responsible for their operation.

In the consideration of implementing that kind of a direction, there would have to be some significant discussion with municipalities because it does change the relationship of the current health unit to their operators at the municipal level.

It's not an easy change to contemplate. Particularly when you then look at regions versus counties in terms of their operations, it's a complicated discussion.

M^me^ France Gélinas: Has either party, either the municipalities, counties or the Ministry of Health, shown an interest in having this dialogue, or is this something that is not being talked about?

Mr. Ron Sapsford: To my knowledge, there's no active discussion of that question at the moment.

M^me^ France Gélinas: Okay. Since you've opened it up, can I get the new report on the number of permanent full-time medical officers of health for each of the 36 health units, which ones are seconded, which ones are sharing health units, which positions are being—you know, we have a chicken in every pot. We have medical officers of health, but not all of them are permanent full-time. Could I have a report on this?

Mr. Ron Sapsford: Yes, certainly.

M^me^ France Gélinas: Thank you. You're familiar with PSLRTA? I'm not too sure how to pronounce it, but we've used it enough. There's an expectation in the field that the people working within the health unit would be covered by PSLRTA; is this something that the Ministry of Health will request in the near future?

Mr. Ron Sapsford: The application of PSLRTA to what question?

M^me^ France Gélinas: To the staff working in the health units, so that they would have security if any movement is done to their place of work.

Mr. Ron Sapsford: Oh, I see. When PSLRTA was amended, it was put in place, if my memory serves me correctly, with respect to decisions that local health integration networks would make. Public health units are not under the jurisdiction of them, so I would have to check the question. I'd be happy to do that, in terms of reallocation.

M^me^ France Gélinas: My understanding is that if the restructuring happens under the review that was done, it would not be a LHIN integration; it would be the Ministry of Health/municipality etc.

Mr. Ron Sapsford: Yes.

M^me^ France Gélinas: So those workers are not covered. My question is, are there thoughts about the Ministry of Health requesting that they be covered?

Mr. Ron Sapsford: That it be amended?

M^me^ France Gélinas: Yes.

Mr. Ron Sapsford: I don't have an answer to that question. Given that there has been no active discussion on the actual consolidation of public health units, the question hasn't been canvassed. As I said earlier, it's a complicated discussion, and this is clearly one of the issues that would have to be talked about before a decision would be made.

M^me^ France Gélinas: Okay.

We know that the new care standards have been rolled out and put in place. Can I have some kind of an update as to how many health units are meeting all of the new care standards that were put into place?

Mr. Ron Sapsford: I'll have, with the Chair's permission, Allison Stuart, who is the acting assistant deputy ministry of public health—

The Acting Chair (Mr. John O'Toole): Two minutes left at this point.

Mr. Ron Sapsford: Two minutes.

M^me^ France Gélinas: I hope she's a quick talker.

Mr. Ron Sapsford: She is.

The Acting Chair (Mr. John O'Toole): If you'd state your name for Hansard, please.

Ms. Allison Stuart: Allison Stuart, acting assistant deputy minister, public health division, Ministry of Health.

The standards were released to all health units on January 1, 2009. The expectation is that all health units will be in compliance with the standards. Work is under way right now to identify and develop how one actually measures that. We can measure widgets in terms of process, but really addressing, "What are the outcomes, and is that community healthier as a result?" is what we're looking at at this present time.

M^me^ France Gélinas: And when do you expect this work to be completed?

Ms. Allison Stuart Prior to H1N1, we expected it to be completed probably by the summer of 2010. I think we will be revising that date.

M^me^ France Gélinas: Okay. Thank you.

The Acting Chair (Mr. John O'Toole): This committee will now stand adjourned until after routine proceedings tomorrow.

The committee adjourned at 1757.

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