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Wednesday 3 November 2010

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Mercredi 3 novembre 2010

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: Douglas Arnott

Président : Garfield Dunlop
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Hansard Reporting and Interpretation Services
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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON ESTIMATES

COMITÉ PERMANENT DES BUDGETS DES DÉPENSES

Wednesday 3 November 2010

Mercredi 3 novembre 2010

The committee met at 1621 in room 151.

MINISTRY OF HEALTH AND LONG-TERM CARE

The Chair (Mr. Garfield Dunlop): We'll call the meeting to order, ladies and gentlemen. We are now resuming consideration of the estimates of the Ministry of Health and Long-Term Care, vote 1401. There's a total of five hours and 34 minutes remaining.

When the committee adjourned yesterday, the official opposition had finished their 20-minute turn. We will now start the next round of questioning with the third party for 20 minutes, followed in turn by the government for their round.

Before that, though, the minister had a comment she'd like to make on an answer from yesterday, right, Minister?

Hon. Deborah Matthews: Yes, thank you very much, Chair. Yesterday, Mr. Clark was asking a series of questions regarding consultants. What I'd like to do is, I want to go back and double-check and make sure that all the answers I gave you yesterday were correct. So I beg your indulgence: We'll get back to you the next time we meet and just confirm that the answers I gave you—we gave them pretty quickly, and I just want to make sure they're right.

The Chair (Mr. Garfield Dunlop): Okay. That's it?

Hon. Deborah Matthews: That's it.

The Chair (Mr. Garfield Dunlop): With that, the third party, you have 20 minutes. Ms. Gélinas.

M^me^ France Gélinas: Before I start with my question, I wanted to express my concern over the response to the questions from the last time the health and long-term care ministry came before estimates. The last time was on October 27, 2009, October 28, 2009 and November 3, 2009.

To be fair, the minister had only been minister for a few days, and then a few weeks, when she came, so a lot of the questions were not answered right away. We understood this and respected this. This is a huge portfolio; we had a brand new minister.

We were told that this information was going to be provided to us, which it was. The problem is that it was provided a year later—actually, four hours before the new set of estimates started.

The Chair of this committee had written to the minister on December 9, 2009, expressing concern, because the 30 days allocated to answer back to this committee had passed, and the committee was still awaiting a response from the ministry to the outstanding questions that were asked.

I'd like to read the letter that was sent on our behalf by our committee Chair, Mr. Dunlop, and it reads as follows:

"On behalf of the Standing Committee on Estimates, I am writing to follow up on the outstanding questions asked by the committee during its consideration of the estimates of the Ministry of Health and Long-Term Care on Tuesday, October 27, Wednesday, October 28, and Tuesday, November 3, 2009.

"More than 30 days have passed since the Ministry of Health and Long-Term Care appeared before the committee and undertook to provide answers to outstanding questions. As of this day"—and it's dated December 9—"the committee is still awaiting responses to questions filed and trusts they are forthcoming.

"The estimates process works well when there is co-operation between the members of the committee and the minister before the committee. Members of the committee take care to keep their questions relevant in the context of the main question: Shall the vote giving authority to spend certain sums of money for specific purposes carry?"—which is what we're there to do. "The ministry, for its part, demonstrates openness in providing information requested by the committee in a timely way.

"In the spirit of co-operation that underpins the estimates process, and on behalf of the committee, I request that the minister table the answers to the outstanding questions as soon as possible.

"Sincerely,"—and it's signed—

"Garfield Dunlop, MPP

"Chair, Standing Committee on Estimates"

I was copied on this, as was everybody else who sits on this committee.

This letter touches on something that is so important for this democratic process to work, and that is openness and accountability. To me, estimates is an important time to show openness and accountability by sharing information, by answering questions, by making sure that this book that we have here—because the Ministry of Health is huge—is something that we can vote for. But, unfortunately, the responses came a year later.

Through the Chair, I was wondering if it would be acceptable to ask the minister: Why did it take so long?

The Chair (Mr. Garfield Dunlop): I have no problem with that question. Minister or deputy, you might want to answer that, if you could.

Hon. Deborah Matthews: Sure; I'd be more than happy to. I want to start by saying that a year is too long, and I'm not going to quarrel with that.

But I do want to say that last year, there were over 80 questions that were asked that were probably more typically dealt with through freedom of information, and there were many times during the course of estimates that actually, there were just questions read into the record, so there wasn't even time given to attempt a response. It really was pretty clearly an attempt to get around freedom of information.

What we've done is we've compiled answers—the response document. It's double-paged and very thick. As I say, it contains a lot of information that otherwise would have been acquired through freedom of information.

It's impossible to really estimate how much money the parties have saved in freedom of information but definitely tens and tens of thousands of dollars of information. We've got the responses. They could have been more timely, I agree, but in fairness, I wasn't given time during estimates to answer most of the questions that were asked.

M^me^ France Gélinas: My follow-up to this is, if we do ask you a question and you tell us that you will get back to us because you don't have the information here—not questions that are tabled. If I ask you a question you can't fully answer and you tell me that you will get back to us, then can we have the assurance that this answer will be forthcoming within 30 days, as is standard for this committee?

Hon. Deborah Matthews: What I could do is tell you that we'll do our best to get answers in as timely a way as possible. We did choose to answer them all at once rather than coming out in bits and pieces. Perhaps you'd prefer to get them back in a different format. We'll get them to you as quickly as we can.

You can imagine that our ministry folks work very, very hard to get the answers to the questions. They'll want them to be right, and sometimes going through freedom of information is a more appropriate way to do it.

M^me^ France Gélinas: I get from this that I would like answers back as soon as possible, and if, as I say, through the course of our discussion, you feel that you want to follow up, I would appreciate that the answers come as soon as you have them.

Hon. Deborah Matthews: Okay, that's perfectly reasonable.

M^me^ France Gélinas: That would be my preference.

Hon. Deborah Matthews: Okay. Let me just ask.

I think that's a very good point. If, in fact, we repeat what happened last year, where members read a series of questions into the record, it will take us longer.

M^me^ France Gélinas: I understand.

The Chair (Mr. Garfield Dunlop): All right.

M^me^ France Gélinas: So can I start with primary care? Some of the questions that I asked last year were partly answered and partly not. I find it a little bit weird, because I attended a—I thought it was an opening but it wasn't—celebration where our Premier participated in a family health team where he shared a lot of information about how many there were, the number of physicians who were participating and the number of people who were receiving care, but yet, when I asked those same questions in estimates, I didn't get the answers or I had to submit an FOI.

I will try it again. The first one is: How many family health teams are currently operating across our province? I would like to have staffing numbers broken down by the number of physicians—not necessarily paid by the FHT—who are associated with the family health team, either through a blended-salary model, either through a—the name escapes me right now. Anyway, how many physicians are associated with the FHT model? How many are operating? I want to know the number of positions of all of the allied health professionals that are funded through the FHT model, and that would be nurse practitioners, nurses, physiotherapists etc. Is that something you have here?

Hon. Deborah Matthews: I think we have around 152 operating now. We've got another seven or eight that are going to be opening very soon. I actually opened one this morning up in Omemee. Then we have another 30, bringing the total to 200 that will be open, we anticipate, within the next year; probably less than a year from now we'll have 200 up and running.

1630

Of course, many of those family health teams have many sites, so that's the number of teams, not the number of sites.

In terms of physicians—do you happen to have a total there? I'll answer, and then the deputy can maybe give more detailed information.

When we have the full 200 up and running, we will have three million patients attached to family health teams. Those are people who would be served in those family health teams and would have access not just to the physician services there but to all of the allied health professionals working on the family health teams—nurse practitioners, nurses, social workers, dietitians, pharmacists, physiotherapists, occupational therapists—a number of different allied health professionals.

Each model is different. They don't all look the same, but what is the same about them is that they have a significant complement of allied health professionals. It usually works out to about one allied health professional for each physician, but it's the combination, the array of supports that is so extremely appreciated by the patients and by the physicians. It's a model that's working very, very well.

As I say, I was at the opening of one in Omemee today. I met a new doctor, a new graduate from McMaster's school of medicine. He wasn't from the area but was drawn to the area because it was an opportunity

to work on a family health team. It's a model that's working.

We'll just see if we have the information that you requested.

Mr. Saäd Rafi: We will try to verify these and can get you this as a breakdown in writing, as well. Amongst the 151 of the 200 announced—in other words, 151 are operational—there are approximately 1,967 doctors.

Hon. Deborah Matthews: Sorry; how many?

Mr. Saäd Rafi: There are 1,967 physicians. There are 1,539 allied interdisciplinary health professionals who have been approved, and about 90% of those are hired. There's a small delta who are still in the hiring process, and that varies across the health professionals, as the minister has said, but they're all in the 80-percentile-plus level of hired.

I think that's what you were asking, Ms. Gélinas.

M^me^ France Gélinas: No. I would like to know, of those 1,500 allied, how many are nurse practitioners, registered nurses, registered practical nurses, dietitians, mental health workers, social workers, pharmacists, educators and others.

Mr. Saäd Rafi: Sure. Approved, and then I'll give you hired in each category; is that okay?

M^me^ France Gélinas: Sounds good.

Mr. Saäd Rafi: NPs, or nurse practitioners, 361 approved, 307 hired; registered nurses, 508 approved, 469 hired; registered practical nurses, 64, and 57 hired; dietitians, 137, 123 hired; mental health workers and social workers combined—we don't separate the two—291 approved, 269 hired; pharmacists, 77 approved, 65 hired; educators, 28 approved, 23 hired; and the always-popular other health professionals, 73 approved and 54 hired.

That hopefully should add to 1,539 approved and 1,367 hired.

This is a constant and ongoing process, so I unfortunately don't know as of what date these numbers are at, but let's say within 30 to 60 days' accuracy.

M^me^ France Gélinas: Okay.

Mr. Saäd Rafi: Sorry; I should say that probably the last figures we have would be from end of summer, so pre-September, almost 90 days. The constant hiring process is taking place and more progress is being made.

M^me^ France Gélinas: Very good. Of the 151 that are operational, how many are community family health teams?

Mr. Saäd Rafi: I'll have to get you that answer. I don't think we have that breakdown here.

M^me^ France Gélinas: Okay.

Hon. Deborah Matthews: Can I just clarify the question? Community family health teams as opposed to—

M^me^ France Gélinas: They're called community-sponsored family health teams when the governance model is—

Hon. Deborah Matthews: A community board as opposed to a group of physicians?

M^me^ France Gélinas: That's correct.

Hon. Deborah Matthews: So it's the governance?

M^me^ France Gélinas: That's correct. I'm interested in knowing how many of the community family health teams are operational—so that's 151 or 152 operational—and the difference to make it to 200. I'm also interested in knowing if there are community family health teams in the 50 that are left.

Recently, we talked about a million people who now have access to primary care that didn't have access before. I'm just curious: Where does this number comes from?

Hon. Deborah Matthews: Let me start, and then we'll hand it over if need be. We do a rolling survey, and we ask people in that survey about their health care needs. One of the questions is, "Do you have access to primary health care?" That is where we get that number. The Ontario Medical Association, for example, has a different number, which actually is a higher number. They calculate the number somewhat differently.

Perhaps I'll hand it over to the deputy, and he can get you more detail on this. I think it's an important question.

Mr. Saäd Rafi: Yes, and we're also trying to get a hold of the assistant deputy minister who's responsible for this area.

We derive this data from something called the primary care access survey. This is a quarterly survey. The data on the one million attached patients is a function of quarterly surveys from July 2009 to June 2010. It's essentially similar to Stats Canada surveys. What it does is it looks at both the adult population—adult in this case defined as 16 and older—and then the child population, aged newborn to 15. This data is derived from the survey conducted for us by the primary care access survey. It is as current as June of this calendar year. It also then breaks down the number of patients by sex and age group who have reported having a family physician.

At that point, I think we'd maybe ask Joshua to come to the table and put him on the spot. This is Dr. Joshua Tepper, who is responsible for our primary care access area. The question that's being asked by Ms. Gélinas is how we derive one million attached patients. I gave a very poor rendition of the primary care access survey.

Hon. Deborah Matthews: Maybe before Josh gives the scientific answer, I think that all the MPPs sitting around the table actually know themselves what's changed in their community. When I think back to when I took office in 2003 and leading up to that, the number one call I got in my constituency office was about access to primary care, people absolutely desperate to get a family doctor. I don't get those calls anymore—I get them very rarely, and if I do, I can easily connect them with Health Care Connect. It just is not a problem in many parts of the province now. We know it's not a problem that has been solved everywhere, but we know that we are significantly further ahead just judging by the phone calls to our constituency offices.

I'll pass it off to Josh.

Dr. Joshua Tepper: Thank you, Minister and Deputy. Again, I'd be interested, as well, to hear your outstanding concerns or areas of interest about the survey. It is a

phone-based survey, and it has been developed in conjunction with research expertise in the academic world. We've been using this with reliability now for over five years. While there are limitations to a phone-based survey—I know they're fairly well documented in the literature—within a context such as Ontario, those limitations are very minimal, so in that sense I think it's a very defendable survey and it has shown consistency over time.

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I think I might also—and I ask the deputy for permission—point toward another way that we measure unattached patients, and that's through the Health Care Connect program. Actually, we just had a chance to present the Health Care Connect program two days ago in Montreal as an example of excellence in primary care in Canada. We had people from all across Canada come to learn about Health Care Connect on Monday at a Canadian Health Services-funded conference on primary care innovation.

The exciting part about Health Care Connect is that it's a way of not just doing phone surveys and finding out who doesn't have a doctor or primary care provider or nurse practitioner, but actually to actively manage that individual and connect them to a primary care provider, and to do it based on priority of need.

One of the important things, and it picks up on the minister's comment, is that the program has been very successful and we've had about 80,000 people participate. The fact that it is only 80,000 is a remarkable testament—and it's roughly 18 months—to the fact that the need is far less than it would have been if we had launched the program, say, five years or four years ago.

The good news is that of those who have chosen to use it, we have matched well over 50% of them, and if you take a look at the sickest individuals on that list, we have matched the vast majority of those individuals through Health Care Connect to a primary care provider.

M^me^ France Gélinas: A couple of comments before I dig a little bit more. The first one is: Can you table those survey reports? Can you share them with us?

Dr. Joshua Tepper: The primary care access survey?

M^me^ France Gélinas: Correct.

Dr. Joshua Tepper: There's no individual, specific data, so I suspect we could certainly provide data.

M^me^ France Gélinas: Okay. I would appreciate it if you could share it with the committee.

Dr. Joshua Tepper: I'd be willing to do that. I think, although we do it quarterly, it's most robust when we look at it on an annual basis, so we should probably provide that to you.

M^me^ France Gélinas: I would appreciate that.

Two parts that are troubling: I'm really happy that the phone calls have gone down in London. Can I forward the phone calls from Nickel Belt to London now? Because they have not gone down in Nickel Belt and they are still just as desperate as they were when I started.

The other thing that is troubling with Health Care Connect is that people who move from other areas are reluctant to leave their family physicians behind, because you come to Nickel Belt and you have zero chance of getting a new family physician. If you're lucky, you'll get into one of the new nurse practitioner sites; otherwise, nobody's taking patients. Why is it that Health Care Connect won't help you? You have to resign from your family physician where you were before, before they will help you. I tell people coming to Nickel Belt not to do this, because Health Care Connect won't be able to find you a physician.

Hon. Deborah Matthews: Let me just say that we acknowledge that there are parts of the province where there is still a serious lack of primary health care providers, and the northeast, of course, is one of those areas, as is the northwest of Ontario. We have totally revamped the underserviced area program now, so there are significant financial incentives for physicians to locate in the north, through the NRRR program.

It used to be the case that there were so many areas that were designated underserviced that new physicians could choose to locate in a place like Burlington and receive almost as much as if they located in Lively. Now there's a difference of about $130,000 over four years between locating in a place in northern Ontario and a community in southern Ontario. We're really taking that incentive seriously and it is making a difference.

We opened up a medical school in the north, right? The northern school of medicine is producing doctors, many of whom, of course, are from the north and want to practice in the north. Because we now have the data from places like Health Care Connect, we can make strategic investments like nurse practitioner clinics, like family health teams, in areas where we know there is a problem. We've got much, much better data now than we've ever had before about what areas need that kind of primary care, and we can make those strategic investments.

We haven't got the problem solved; we know that, but what I can tell you is, we've got a handle on it. There are parts of this province—Windsor, the Cobourg area—where doctors are actually advertising for patients instead of the other way around. We would not have seen that seven years ago; we absolutely would not have. So I look forward to the day when doctors are looking for patients in Nickel Belt.

M^me^ France Gélinas: So do I.

You didn't answer my question about why you have to let go of your primary care provider to qualify for Health Care Connect.

Hon. Deborah Matthews: That was the way the system was set up initially, to attach unattached patients, because that's where the greatest need was. We wanted to get people attached. I think, as we further refine the program, it's something that we should have an open mind to.

The Chair (Mr. Garfield Dunlop): Thank you very much to the third party. We'll now go to the government members for 20 minutes. Ms. Sandals, do you have a question?

Mrs. Liz Sandals: Yes. Actually, before I go on with my question, I was just going to comment on the last discussion, because I too would have a riding where, when we first came in, in 2003, my constituency office phone just rang off the wall with people who were desperate to find a doctor and who weren't able to. Absolutely, Guelph qualified as an underserviced area under the old way of designated underserviced area. What has gradually happened, as we've gone from 2003 to now, is those calls are now very rare, and Guelph, in fact, is one of those areas where new physicians coming into the family health team often are advertising for new patients.

I also wanted to comment on what Dr. Tepper was saying about the methodology of doing the phone survey, because the other thing we began to realize was that—actually, before I came in, there had been a physician recruitment group put together in Guelph, which continued to work through 2003, 2004, 2005. The physician recruitment group actually started a wait-list of people who were looking for physicians, but what became very clear after a while was that the wait-list didn't have much attachment to reality because some of the people on the wait-list actually still had a doctor in Burlington or Oakville, for the sake of argument. They were looking for one in Guelph but they actually had a doctor someplace else. It was actually like there was gridlock.

Some of the people had found doctors in Guelph, but there was no mechanism to remove yourself from the wait-ist, and when new doctors came to town, they often didn't refer to the wait-ist; they used their own way of finding patients. What gradually became clear was that the wait-ist mechanism wasn't really working. I think what Dr. Tepper and his group are doing, which is doing a phone survey, probably gives the Ministry of Health much more accurate information about who is actually still out there looking for a doctor and where that is happening than if you had referred to this informal wait-list that the community had structured but which had no capacity to really manage it in a sophisticated way. So just that sort of comment on what was happening.

Minister, I actually wanted to talk about eHealth because I think when you appeared here last year, you probably got a lot of questions about eHealth. I wasn't actually on the estimates committee; I'm just visiting today. What I did spend a lot of time—at the same time was the public accounts committee, where eHealth was obviously also a topic of high interest. Certainly, we heard a lot at public accounts because we were dealing with the auditor's report around things that were unacceptable.

1650

We also got, though, a flavour of what the interim management was doing in terms of putting new processes in place, making sure that consulting contracts for the things that seemed quite weird, like answering telephones, were phased out or cancelled. We heard a lot about the good work that they were doing in recruiting internal management to do good things, the recruiting that was going on to replace some of the positions and some of the board members.

But that was, again, in the framework of public accounts a year ago. So it would be really interesting to get an update—we've heard the bad things; good things are happening—on where we are really at now in terms of what's happening with eHealth, what accountability structures have been put in place, what transparency structures have been put in place and just where we really are in that intervening year.

Hon. Deborah Matthews: Thank you very much for the question. I just want to start by saying how vitally important it is that we continue to get electronic health records for the people of Ontario. I don't think it's a stretch to say that the future of our health care system depends on us making measurable gains when it comes to electronic health records for people, so I very much appreciate the question.

You know we have new management. We have a new CEO and a new chair. Ray Hession was brought in as the chair of eHealth Ontario. Greg Reed is the new CEO of eHealth. I think he has been on the job about five months now and is making a remarkable difference in the organization. The use of consultants has declined from almost 400 to just over 100, so we have a quarter of the consultants that we did have.

We learned from what the Auditor General discovered when he looked at eHealth Ontario. We have very tough procurement rules when it comes to consultants. Those are changes that were necessary. We've got quarterly procurement reports on the use of consultants. All the expenses are reviewed by the Integrity Commissioner and are posted online.

We're really starting to see that eHealth has made significant progress over the past year. If you don't mind, I might talk about some of those achievements now.

Mrs. Liz Sandals: Absolutely.

Hon. Deborah Matthews: I was able to announce yesterday that we have hit a very important milestone: five million Ontarians now have their health care managed using electronic medical records in their family physicians' offices, five million out of a population of 13 million. That's an increase of 80% in the last year alone, and we're not slowing down; in fact, we're speeding up.

What we're finding is that doctors are very enthusiastic about coming on board, because they're really starting to see the improvement in the health care they can provide. They can immediately see if there are drug interactions that might cause problems for their patients. They can immediately access reports that have been sent in on their patients. It's just a much more efficient way of dealing with the extraordinary magnitude of information that they receive. The physicians like it, and the patients like it. They have confidence in the system. We're moving forward on more and more doctors getting hooked up with electronic medical records in their practices.

The Ontario Medical Association has been a very strong partner with us, and they actually work to get the doctors trained and converted to the paperless office. I

was actually in a community health centre today where they just do not have paper records; they have completely converted to electronic records, so that's terrific. We're making big strides on that.

You'll remember that one of the criticisms that the Auditor General had of eHealth was that we had built this great highway, but there weren't very many cars on it. He was referring to the infrastructure that had been built. We've now got five million cars, the electronic medical records, on that highway. We're also using up a lot of that highway with some of the big trucks, and those would be things like telemedicine. We actually have almost doubled the number of telemedicine consultations that have gone on. Just in the past year, we've doubled the use of telemedicine.

I see it first hand. I was at a community health centre today in Port Hope. They now are hooked up to the Ontario Telemedicine Network, where patients can come in and, right in their own community, have a consult with a physician in another community. It saves them having to go into a larger community and they get access to that expert care right there in their community.

The other place where telemedicine is just doing extraordinarily fine work is in the more remote communities in the north. Again, I saw the James Bay coast, where those small communities were just getting hooked up to the Ontario Telemedicine Network. In that case, it meant that they might not even have to be transported to another community for that consultation; they could get what they needed. It's one thing not to have to drive from Port Hope to Toronto; it's another thing not to have to fly in from Fort Albany to Timmins. We've had great, great progress on the telemedicine front.

What I think is a very exciting initiative is ePrescribing. We're running a pilot now where the doctors are actually prescribing electronically. We've got to make sure we get it right, but it will reduce errors, there is no question about it; it will reduce fraud. I think ePrescribing has huge potential.

Another area where eHealth has made extraordinary progress is on the issue of diagnostic imaging. All our hospitals now are filmless. The old X-ray films have gone the way of the typewriter. It's all digital, and there is significant ability now to actually, in real time, have a radiologist specialist reading that image in, say, a large academic health science centre, and the patient can stay right where they are. In southwestern Ontario, the Erie St. Clair LHIN and the South West LHIN—every single hospital in those two LHINs is now connected so that they can have those diagnostic images read within that network. It improves efficiency, because all the diagnostic images are in one place. The radiologist can click to see the history, he can see different tests that have been done, and it's very high-quality resolution. I'm talking X-rays, MRIs, CTs, mammograms—all of that diagnostic imaging. Again, we've made huge progress on that front when it comes to eHealth.

In the Champlain region, the seven hospitals again are hooked up to that kind of network. What it means for patients is they can fall, need an X-ray, go to the Deep River hospital, have a specialist in Ottawa read that image and determine whether or not that patient needs to be transported, and they can do it, as I say, in real time. So that's a very big advantage for patients who live outside of where the big academic health sciences are.

1700

Similarly, the emergency neurosurgery image transfer system has neurosurgeons on call. That one tool has prevented 264 patient transfers so far, at a cost of $26 million. So it's very cost-effective and is actually saving patients from having to go out of country to get the care they need.

Another aspect of eHealth that is proving to be a marvellous tool is the drug profile viewer. What that means is, all the emergency departments have access to the prescriptions of all people who get their drugs through the Ontario drug benefit program. That means everyone over age 65, people on ODSP and people on social assistance. So when that patient goes in to an emergency department, they can instantly pick up the drug history of that person, they can see what drugs they're on, and they can make a much more informed choice. That's 24 hours a day, seven days a week, and really helps with the problems associated with errors around drug interactions. We know that's a very serious problem. The drugs can be such an important part of a person's care, but if the drug interactions are not properly managed, it can be a big, big problem.

Then we've got 1.7 million children in the eCHN system covering 100 hospital sites.

So we're really excited about the progress we're making, and we look forward to adding even more capability to eHealth.

Deputy, did you want to add anything on that front? Okay, thank you.

Mrs. Liz Sandals: How are we doing for time, Chair?

The Chair (Mr. Garfield Dunlop): You've got just over three minutes.

Mrs. Liz Sandals: Okay. Just let me follow up on that a little bit. Certainly the X-rays and being able to read the digital imaging is something that I know we have the capacity to do in my LHIN as well. I notice Mr. Arnott is here, and if you get an X-ray or a CT scan at his hospital up in Fergus, it may well be the folks in Guelph who are reading it so that they don't have to have the diagnostician physically there. The diagnostics are being done in Guelph. So there is that e-highway capacity.

One of the other things I notice going into the biggest of the family health teams in Guelph is that they also seem to be picking up lab tests from some of the local medical labs and seem to have the lab results showing up very quickly because they're using e-records. Do you have any information about the access to the lab tests so you don't have multiple doctors ordering the same test over and over again?

The Chair (Mr. Garfield Dunlop): A couple of minutes, Minister.

Hon. Deborah Matthews: You're absolutely right. That's one of the features that makes it so appealing for physicians; they can get the lab reports transmitted electronically to them. They get notified when a new report comes in and they can easily bring that into their system. It's one other way.

I had a physician showing me how she uses eHealth. She can actually get reports generated through her system, so she can see how she's doing as a physician compared to other physicians when it comes to ordering tests. We know that, for example, there are certain tests that diabetics need on a regular basis. That's one of the ways we measure excellence of care when it comes to diabetes: what percentage of your patients are getting these three tests at the intervals they need. Physicians can actually generate that information about themselves and compare it to other physicians. She said, "That's the greatest incentive there is, if I can see, at the click of a mouse, how I'm doing and where I need to actually focus more attention." So, it really is improving the quality of care for people, because they have access to information that would be there in the paper records but very, very difficult to compile.

The Chair (Mr. Garfield Dunlop): Thank you very much to the government members. We'll now go to the official opposition. Who has the first question? Mr. Chudleigh.

Mr. Ted Chudleigh: Thank you, Mr. Chair.

Welcome, Minister. I think you probably know why I'm here: Milton District Hospital expansion. I'm going to slip through some of this pretty quickly, because I've made you aware of these issues in the past.

As you know, Milton is the fastest-growing community in Canada. The rate of growth is outpacing all previous estimates and projections. During the past six years, 60,000 new people have moved to Milton. Another 43,000 will be arriving in the next five years. Over the next two decades, Milton will become the largest community in Halton region, outpacing Burlington and Oakville. This significant urban community is still served by an 86-bed hospital facility designed and built to serve 30,000 people. Milton District Hospital has not received approval for any added service capacity in the past 25 years.

No other hospital in the region, including the new Oakville hospital—I emphasize that—is planning to provide core hospital services to Milton residents and its growing population, as it has been an assumption that the Milton hospital will grow along with its community.

Halton Healthcare Services, which runs the Milton hospital, has clearly and consistently presented a well-thought-out, responsible and credible plan for moving ahead to redevelop and expand Milton District Hospital:

"We"—being Halton Healthcare Services—"have been and continue to be ready, willing and able to engage with the ministry and our LHIN on next steps—finalizing the project's scope, completing the functional program and confirming the requirements for interim coping strategies.

"Our LHIN has communicated its strong support and its own preparedness to engage in this work immediately."

The town of Milton has experienced exponential, unprecedented population growth. Milton District Hospital has inadequate, undersized, outdated physical facilities and aging infrastructure and has a critical and urgent need to expand its facilities. No other hospital has been or is currently planning to provide any services to the population of Milton—I can't stress that point enough.

Halton Health Care Services has developed a responsive plan to address expansion of Milton District Hospital and has shared it with the Ministry of Health and Long-Term Care. It has highlighted the urgency of the early-start components: "It is paramount that our project advances now to begin the next phase of planning. If not, the future needs of the community will be further compromised," and that compromise is putting patient health in danger.

Lucy Brun, a partner with Agnew Peckham health care planning consultants noted to the local health integrated network in the fall of 2009 that over the course of more than 25 years of hospital planning, she has never before been involved in addressing a situation like the one that exists in Milton—that's over 25 years of her looking at hospitals. She notes "an urgent and compelling clash of extremely rapid growth being inadequately addressed in a completely exhausted, undersized facility that is totally incapable of meeting contemporary standards and has been waiting for 10 years for expansion."

Mississauga Halton LHIN Chair John Magill, in his December 3, 2009, letter to you, says: "It is critical that the redevelopment of the Milton hospital be considered a high priority of the ministry capital planning process. The current facilities are exhausted, outdated and undersized and cannot accommodate current patient volumes or future hospital service needs…. The current Milton hospital is incapable of supporting modern-day services…. It is imperative that this capital request move to the next phase of capital planning." I underline the words he used, and these are not weasel words: "critical," "high priority," "exhausted," "outdated," "undersized," "incapable," "imperative." Those are strong words for the chairman of a local health integration network to use.

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"While the Ontario government has provided Halton Healthcare Services with a planning grant," which was submitted in September 2008, "it has yet to authorize the hospital to move forward on the next stages of the capital approval process.

"Halton Healthcare Services needs (1) support for the proposed Milton District Hospital master plan for 2016; (2) approval to proceed immediately with the functional programming of the redevelopment of Milton District Hospital; and (3) approval to proceed immediately with the planning for the early works project," the early works project being one that—because of the population growth, we won't be able to get to a completed hospital in time to service the needs of the community and the

early works project will be a system of coping strategies to get them through to that completed hospital program.

The functional program, which I believe is in the $4-million to $5-million area, could move forward immediately without any capital infusion in this fiscal year. The hospital is in a position, because of some frugal planning, to move forward with that study and get through to March 2011 before any funds from the ministry would be needed.

Minister, will you move forward with the Milton District Hospital process?

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

Hon. Deborah Matthews: Thank you very much.

I guess I want to acknowledge that Milton is a very rapidly growing community; there is no question about that. But there's also no question—

Mr. Ted Chudleigh: The fastest in Canada.

Hon. Deborah Matthews: The fastest in Canada.

Here's what I think we really need to understand: We came to office in 2003. There was a massive infrastructure deficit. There was not just a massive fiscal deficit, there was a massive infrastructure deficit. Appropriate levels of capital investment had not been made for many, many years right across the province, so we embarked on ReNew Ontario. ReNew Ontario was a five-year plan. It has seen over 117 major hospital projects under way or complete over the past five years.

I think it's important that we all understand that we have made extraordinary, unprecedented historic investments in capital infrastructure in this province over the past seven years. That cost us money. There are some who are critical of us, but there is still unmet need for capital infrastructure spending, so we are now looking at what we need to do next and we are working very hard on developing a next-10-year infrastructure plan. Of course—

Mr. Ted Chudleigh: When will that be released?

Hon. Deborah Matthews: We're working on that now with the Minister of Infrastructure.

Mr. Ted Chudleigh: I would point out to you, Minister, that in 2003 Milton was embarking on its functional planning stage from a process that started in 2001. The land had been designated, the program was moving forward. If that program had been held to, the Milton hospital would have been open today. Your government stopped the development of that hospital and didn't restart it again until 2007, in Milton's case.

The words have been passed on by Lucy Brun and also the chair, John Magill, as to the urgency, and the danger that patients are being placed in because of the inadequate service that they can expect from Milton District Hospital is severe. It puts patient life in danger, Minister. I want you recognize that fact.

I know you're not going to give me a date as to when you are going to announce this. I hear what you're saying. With that, I would pass on to the next questioner.

Hon. Deborah Matthews: I would like to finish my answer, if you don't mind, because this is a very important question, and I think it's important to acknowledge where we are in that process. We have, as you said, approved a development grant in July. The work has been going on with the hospital, with the LHIN, with the ministry—

Mr. Ted Chudleigh: July 2007?

Hon. Deborah Matthews: July 2007, yes. The LHIN has endorsed the redevelopment of the Milton hospital site to support increased emergency room, ambulatory care and related in-patient obstetrical and medical surgical capacity, with the understanding that a robust review and assessment occur at the functional program stage of capital development by Halton Healthcare Services and the LHIN on current assumptions and estimates, taking into account population growth, population aging and the impact of other investments that are being made.

I think it's very important that people understand that the brand new, yet-to-be-built but committed Oakville-Trafalgar hospital is actually located in your riding. To suggest that your constituents will not benefit from the Oakville hospital is simply not accurate.

Mr. Ted Chudleigh: My constituents in Oakville will benefit, but not my constituents in Milton. I stressed in my question that there is no capacity being built in the hospitals surrounding us. Credit Valley is not far from us, and Burlington hospital is not far from us, but there's no capacity in those hospitals for Milton residents.

Each community in Halton, through the Mississauga Halton LHIN, is expected to develop their own capacity. That was a principle that was put down by your government, and it has been adhered to. The Oakville hospital is being developed based on Oakville needs.

Let me point out that Milton is the fastest-growing community in Canada, but the number of houses that are built in Oakville is just minusculely below the houses that are being built in Milton. All of this growth in Halton is due to Places to Grow, which was mushroomed because your government shut down the Oak Ridges Moraine, and the 80,000 houses that would have been built there. I don't disagree with that decision other than that there could have been some houses built. The whole thing isn't gravel; you could have built some houses in there. That has caused the exponential growth in the Halton area.

There's only two things that the provincial government has to live up to in that area, one being highway construction, which is sorely lacking. The second is health care, which you've dropped the ball on completely in Milton.

Hon. Deborah Matthews: Excuse me just a second.

Mr. Ted Chudleigh: Oakville is a different story.

Hon. Deborah Matthews: When you were in office, you had no plan. We have a very aggressive plan.

Mr. Ted Chudleigh: We had already started this hospital—

The Chair (Mr. Garfield Dunlop): One at a time.

Hon. Deborah Matthews: Yeah. You guys made lots of promises; you didn't fulfill them.

But what I do want to say is that this is an issue we're taking very seriously. The Oakville hospital will support your constituents, will provide specialized services—

Mr. Ted Chudleigh: That's not the mandate that your government gave us.

Hon. Deborah Matthews: If I could just say, what I'm taking from this, and I hope you'll confirm it, is that you will support us when we come forward with a budget that includes more infrastructure development. You can't say, "Only in my riding will I support infrastructure." You've got to support infrastructure across the province. You're getting a brand new hospital in your riding. That's something that we're going to have to pay for, and we're going to need your help to do that.

Mr. Ted Chudleigh: It's a P3; you're not going to pay for it.

The Chair (Mr. Garfield Dunlop): Okay. So—

Hon. Deborah Matthews: Excuse me, could I just clarify that?

The Chair (Mr. Garfield Dunlop): We'll get on with the next question. If you've got more questions, Mr. Bailey.

Hon. Deborah Matthews: Can I? I just have to.

The Chair (Mr. Garfield Dunlop): Okay, Minister, do a quick answer here.

Hon. Deborah Matthews: The comment from the member that, "It's a P3; we don't pay for it" just demonstrates a remarkable lack of understanding of hospital funding. We don't do P3s; we do alternate financing, and we do—trust me—pay for them.

The Chair (Mr. Garfield Dunlop): Okay. Thank you, Minister.

Now we'll go to Mr. Bailey.

Mr. Robert Bailey: Yes. I've got a couple of questions here, Minister. I'll be real quick; it won't take long.

We've got a brand new hospital in Sarnia, Bluewater Health. It was a long time coming, but we got it, and the people are very grateful for that. I was at the sod-turning in October 2007, and I was also at the opening just recently.

Anyway, here's my question, Minister. The former government announced, in 1998, that we were going to build a new hospital. In 2001, the government of Ontario, through the ministry at that time, promised that when the new hospital was built, they would pay to dismantle and take out the old ground surfaces and return it to green space once the new hospital was in place.

Today, the city and Bluewater Health have been unable to receive assurances from your ministry that that promise and that commitment would be fulfilled, so I'm asking you today: Will you commit to working with the mayor and council of the city of Sarnia and also the board of Bluewater Health so that when the old Sarnia General Hospital finally is no longer in use, now that the new hospital is opening—and will you commit to funding those renovations to return the site to greenfield?

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Hon. Deborah Matthews: I'm sure you wanted to say thanks for a new hospital.

Mr. Robert Bailey: Yes; I did say thank you, yes.

Hon. Deborah Matthews: Because yours is one of the 18 brand new hospitals that we've got across this province, and it's because we were prepared to make investments that we have that.

There is a process for decommissioning the old buildings, and of course, we will happily work with you to—

Mr. Robert Bailey: I just need the commitment to work with the city and with the board of Bluewater Health.

Yes, I'd like to say thanks because it's a lot to do with that hospital that I'm here today.

Hon. Deborah Matthews: Indeed. I don't know if the deputy has anything to add to the decommissioning issue.

Mr. Saäd Rafi: No, not substantively.

Hon. Deborah Matthews: Okay.

Mr. Robert Bailey: Okay, thank you.

The Chair (Mr. Garfield Dunlop): Do you have another question?

Mr. Robert Bailey: No, I'm done.

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

Mr. Steve Clark: Just quickly, I have an issue I want to bring to your attention. It's regarding the Brockville Mental Health Centre—

Hon. Deborah Matthews: I'm sorry; I didn't—

Mr. Steve Clark: The Brockville Mental Health Centre, the Royal Ottawa Health Care Group and the Brockville General Hospital. Ms. Elliott and Ms. Jones came to my riding, and we had a mental health forum regarding the select committee's report. It was very well attended. One of the first—

Mr. Phil McNeely: Chair, can you get him to speak closer?

Hon. Deborah Matthews: We can't hear you.

The Chair (Mr. Garfield Dunlop): Speak into the mike a little better.

Mr. Steve Clark: Sure. One of the first things that was brought up at that seminar was the slowness of the acute care parcel, which is Elmgrove, and the slowness of having that approved by your ministry and accepted by the Brockville General Hospital.

As you know, myself and my predecessor, Mr. Runciman—although we have felt that we should have put the transfer of transitional beds on hold until we worked on some more positive aspects to the site—things like the female secure treatment centre that we're trying to get—there seems to be an undue delay in the transfer of the funds and the approval of the funds so that the Brockville General can accept that Elmgrove portion of the acute services from the Royal Ottawa.

I've got two questions. The first is, when will your ministry be approving those funds so we can get moving? And will your ministry work with our community on the secure treatment side to provide sort of an all-party group that will work on that particular aspect as well?

The Chair (Mr. Garfield Dunlop): Two and a half minutes left, Minister.

Hon. Deborah Matthews: Okay, thank you.

Of course, the history is the hospital restructuring commission—

Mr. Steve Clark: Yes. I know the history.

Hon. Deborah Matthews: —back in 1998, I think, recommended that this move be made. It has taken some time, but we are moving forward. As I understand it, there were three units of patients at the Brockville Psychiatric Hospital to transfer. Two of those units have been transferred, one in the spring of this year and another one in September. The third, the LHINs are working on right now.

Perhaps I will ask my deputy; he's been working on this issue personally.

Mr. Steve Clark: If the deputy's going to respond, the other issue is, because of the uncertainty, staff are not bumping into that acute side. They're going to the forensic unit or the secure treatment unit. There is a possibility that we will not have overnight psychiatry services, that those people in need will have to go to a general hospital or be transferred out of the community. The whole uncertainty is a huge issue in the riding. I want to make that point before the deputy responds.

Hon. Deborah Matthews: I do understand that, and I appreciate that. In fact, in London, I'm dealing with a not-dissimilar situation. I do understand the issue. I know the deputy has worked personally on this issue and maybe can bring you up to date.

The Chair (Mr. Garfield Dunlop): Deputy, you've got about a minute left.

Mr. Saäd Rafi: Okay, thank you.

It is unfortunate that the two hospitals haven't been able to come to some form of resolution. I take your point about the impact on staff as well.

I think we can commit, though, to get to the bottom of this issue. We've had calls and discussions with both LHINs' CEOs, and we'll be coming forward with a plan between them to fund the necessary costs to make sure the transfer takes place in the most expeditious manner possible. We hope to report back to you within, I would say, four weeks or less with a resolution.

The Chair (Mr. Garfield Dunlop): Okay. That's very good. Thank you very much, Deputy and Minister.

Now we'll go to the third party for their next 20-minute rotation. Ms. Gélinas.

M^me^ France Gélinas: I want to bring us back to primary care. The Ontario Health Quality Council tells us that 750,000 people who didn't have access to primary care still don't have access to primary care—and this is over the period of time that you were in power. One of the models that really shows great opportunities for the people who I represent is the nurse practitioner-led clinics. We're really happy with the ones that are operating in my riding.

I'm curious to better understand: You have a commitment of $38 million over three years to implement the 25 nurse practitioner-led clinics. From what I understand, you have spent $8.4 million. Is the $8.4 million spent out of that $38 million for the next three years, or the $38 million is for ongoing?

Mr. Saäd Rafi: Can we get back to you with an answer to that? It's a very specific question.

M^me^ France Gélinas: Sure, 30 days?

Mr. Saäd Rafi: How about 30 minutes?

M^me^ France Gélinas: Even better: 30 minutes is within my 30 days.

So we have 25 that have been announced. How many are operating?

Hon. Deborah Matthews: I believe we have three operating right now. I think Belle River, Sudbury and the third in eastern Ontario—

Interjection: Belleville.

Hon. Deborah Matthews: —Belleville, where the Premier, I think, attended the opening. We announced the successful applicants, and as you well know, it takes some time to get the space, to get the personnel. We have made it very clear to them we want them up and running as quickly as possible.

I'm very, very pleased; one of them actually happens to be in London. I know very well the people who are looking forward to serving the population.

I think we only have three open now, but the others are coming along as quickly as they can.

M^me^ France Gélinas: Okay. I would be interested in the breakdown of the $38 million over three years that you have committed for the implementation of the 25. Can I have a breakdown as to how much per year? I take it it starts in 2010-11, then 2011-12 and 2012-13. How is this money going to be distributed?

If you can also give me a breakdown of the full-time equivalent position per professional, as in how many FTE nurse practitioners, nurses, dietitians etc. for this model of primary care. Is this something you can do now?

Hon. Deborah Matthews: My understanding—and correct me if I'm wrong—is that we announced the successful applicants, but then we will be working with them to actually come to an understanding of exactly what the staffing complement is, what their budgets will be and so on. That work is under way right now, as we speak. We won't be able to actually tell you how many people are going to work there because we don't know yet.

Perhaps the deputy can add something.

Mr. Saäd Rafi: Just by way of a partial answer on the allocation, it would not be unexpected to have the dollars allocated when NPLCs are operational, and the NPLC model takes a little bit longer to get established. So just to supplement the minister's comment, once operational, we can tell you the interprofessional breakdown, because they would, in their application, give some notion of what that would be, as you well know. But then, depending on where they end up in the actual hiring process as well as patient need within that catchment area, that number may vary—not dramatically, but it may vary.

The other thing is, since we have three operational, I can't tell you that—we're certainly not taking $38 million and dividing it by three in each year; we're taking it on an operational basis.

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We need to make sure that the organization is in place. They're new models, so they're taking a little bit longer than a family health team to get established. Nevertheless, as you say, we would hope that over the next three years, we can get the 25 operational, and that's the plan.

M^me^ France Gélinas: I'm surprised to hear this. Why do they take longer than a family health team to get established?

Mr. Saäd Rafi: I can get you some more details on that, but I think much of that sometimes has to do with finding appropriate lease space.

There's a myriad of factors that go into this. It isn't just a coalescing of the actual professionals. That's probably relatively easier than it is to get space and get incorporated. Many of these individuals have not experienced the incorporation process. They're health practitioners; they're not corporate accountants or lawyers. They need to search out that kind of advice to constitute themselves in the best manner possible.

I think it's fair to give them the proper time to, as the saying goes, get their feet on the ground.

Hon. Deborah Matthews: What I'd like to add, though, is that when we were determining that we had far more applications for clinics than we had the ability to fund, one of the criteria we looked at was, "How quickly can you get up and running?" Timeliness is important to us. We hope to have them all up and running within a year. But over the course of the three years, they'll get established and move from there.

M^me^ France Gélinas: I understand that the salary scale for the physician collaborator—because every nurse practitioner-led clinic needs to have a collaborating physician—has been established at about the midpoint of a community health centre physician. I'm wondering what motivated that decision.

Mr. Saäd Rafi: We'd have to go back to determine what the decisions were at the time and what the calculation was—how it was based on, comparing to—if indeed it was compared to the community health centres as well. That will likely fit into the 30-day timeline.

Hon. Deborah Matthews: What I can tell you is—and you know this, because you've been actively involved in facilitating the issue—the model that we started out with, in terms of compensation for the physician, didn't turn out to be one that was working very well for the nurse practitioners, so it was something that we had to go back and take another look at and determine what would be fair compensation for those physicians.

To land on where community health centres are seems to me to be kind of the place we should be. What's important to us and, as you well know, what did cause some delay was getting that right combination of nurse practitioners and physicians.

M^me^ France Gélinas: Okay. Because it used to be—a fee-for-service physician model does not work when you're doing collaborating work in a nurse practitioner-led clinic. The salary model works well. It's just odd to have a physician working next to a community health centre, and they both do similar work but they don't get the same pay. I don't understand where this reasoning came from.

Hon. Deborah Matthews: Let's just see if we maybe have—

M^me^ France Gélinas: The answer?

Hon. Deborah Matthews: —the answer for you.

I thought what you were saying was that the compensation is the same as community health centres.

M^me^ France Gélinas: No; it has been fixed at the midpoint. Let's say a physician in a community health centre makes $180,000 a year, max. The salary scale goes from $128,000 to $180,000. The midpoint of this is about $155,000. A physician who works in a nurse practitioner-led clinic is at $155,000, the midpoint. It doesn't matter if you have two, three, four, five years of experience with them. You're at the midpoint.

Mr. Saäd Rafi: I guess, initially, I would say that we have three operational. We're learning, in terms of the experiences that those NPLCs have. It's my understanding that the NPLC receives a stipend of approximately $838 per month for every nurse practitioner full-time equivalent to provide to the collaborating family physician for their own consultation.

We also want to review that and determine over time, on a longitudinal basis, whether that's an appropriate landing point—salary projections or different physician models. This is not a science, so we're trying to learn based on the operational experience of the three NPLCs.

M^me^ France Gélinas: Okay, so my—

Mr. Saäd Rafi: You know the salaries better than I do off the top of my head. That's demonstrably clear. I'm just giving you the information that we have at our fingertips. We're trying to provide that stipend to encourage the physician to work with the nurse practitioners, and also to give the nurse practitioner-led clinic the ability to attract a consulting physician, such that the model can work in the most reasonable manner possible and in the manner that was intended in the community.

M^me^ France Gélinas: Okay.

Hon. Deborah Matthews: If I could just add to that, we're really excited to have the model of nurse practitioner-led clinics.

M^me^ France Gélinas: So am I.

Hon. Deborah Matthews: As the deputy has said, we're just learning how to do this and how to do it right. There is going to be a lot of learning, and we want to be part of the learning.

I do actually have some answers to questions you asked earlier. If I could give those to you now?

M^me^ France Gélinas: Sure.

Hon. Deborah Matthews: So your question was, how many of the 151 FHTs have a community-led board versus a physician-led board of directors? Of the 151, 21 are community-governed; the remaining 130 are either physician-led or have a mixed-governance model.

You asked a question, how many of the remaining 49 non-operational but soon-to-be-operational family health teams will have a community-led board versus a phy-

sician-led board of directors? The remaining 49 comprise 19 in wave 4 that are expected to be operational by December this year and 30 in wave 5 that were announced in August and are expected to be operational by August 2011.

Of the 19 in wave 4, one is community-governed; the remaining 18 are either physician-led or mixed. Of the 30 in wave 5 family health teams, it's too early to tell what type of governance they will have. They're now entering the business-planning stage of their development, and part of that development is designing and confirming their governance model and their board membership. We're hoping to have those by February 2011, and we'll have a better idea then.

M^me^ France Gélinas: Thank you.

Hon. Deborah Matthews: That was before 30 days.

M^me^ France Gélinas: That was way before 30 days.

Hon. Deborah Matthews: Within 30 minutes, I think. We're doing better this year than last, aren't we?

M^me^ France Gélinas: You're doing way better this year.

My last question regarding the FHTs and nurse practitioner-led clinics would be, has the ministry recommended salary scales for the different professionals? Do you have recommended salary scales for physicians, nurse practitioners, nurses etc.? I would like those salary scales to be shared. What are your recommendations for both models?

Hon. Deborah Matthews: We will do our best to get you that information.

M^me^ France Gélinas: Within 30 days?

Hon. Deborah Matthews: If we have it.

M^me^ France Gélinas: I'm batting 1,000.

Moving on to questions about hospitals for a little while, the first one has to do with money. We're in estimates, so good place, eh? We have a 1.5% base funding increase for hospitals but a total of 4.7% increase to hospital funding. Can I have a breakdown in amounts by hospital, if possible—aside from the 1.5%, which I can do the math for myself—for all additional funding for each of the hospitals, whether it was construction funding, high growth, wait times etc.? How was the 3.2% difference allocated?

Mr. Saäd Rafi: May I clarify?

M^me^ France Gélinas: Sure.

Mr. Saäd Rafi: You don't need the 1.5% because you feel you're okay with that.

M^me^ France Gélinas: Well, if you have it, I'll take it.

Mr. Saäd Rafi: Okay. The difference is 3.2%, you're saying? You want that broken down by hospital. You also mentioned construction in there—

M^me^ France Gélinas: I want to know how it was spent. Sometimes you make announcements and you call those announcements "post-construction funding." In Sudbury, it was called that; it was on the big cheque. Then sometimes it's because of high growth. Sometimes it's because of a wait times strategy.

Mr. Saäd Rafi: I understand. Thank you.

M^me^ France Gélinas: You have called those investments by different names. I'm just using the same names you have used.

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Mr. Saäd Rafi: So I guess, through the Chair to the clerk, there are 156 hospitals. This might be one of those that may require some time, but we will do our utmost to get that information to you.

M^me^ France Gélinas: I appreciate it.

Hon. Deborah Matthews: A further complexity to this, because it is health and it's always complex, is that the 1.5% actually didn't go. Each hospital didn't get 1.5%.

M^me^ France Gélinas: Oh my. Okay.

Hon. Deborah Matthews: Yes. So that actually is divided in two. Every hospital did get 0.75%, and then the remaining 0.75% was allocated within the LHINs in a way that was responsive to the needs of their particular LHIN.

What we call a 1.5% base is the aggregate—a 1.5% base increase. Not every hospital did get 1.5%. I bet you want that breakdown, too.

M^me^ France Gélinas: Yes.

Hon. Deborah Matthews: We'll do our best to get that.

M^me^ France Gélinas: It does get more complex really quickly, doesn't it?

The other one is the emergency wait time funding.

The Chair (Mr. Garfield Dunlop): Four minutes left now.

M^me^ France Gélinas: Oh my.

Some of it went to physician initial assessment funding. Some of it went to ambulance offloads. Some of it went to nurse funding. Can I have a breakdown as to where the money for emergency wait times got distributed? You can give it to me by envelope—like so much was allocated for physician assessment, so much was allocated for ambulance offloads, so much was allocated for nurses. But I would also like it per hospital—which hospital got what of the money that was allocated on the emergency wait time funding.

Nothing good ever comes out of a secret.

Hon. Deborah Matthews: No, it's not a secret. I think he just wanted me to say it.

The point is, these are complex calculations. We'll do our best to get them to you in as timely a way as possible. But it is a big project, to pull that number out for each of the hospitals. I'll leave it at that. We'll do our best, but it's not readily available in the format you've asked for.

M^me^ France Gélinas: Okay. What can you share about the process for 2011-12 hospital funding and the time frame for the release of the new hospital accountability planning submission?

Mr. Saäd Rafi: The accountability agreements between the LHINs and the hospital?

M^me^ France Gélinas: Yes.

Mr. Saäd Rafi: I don't think we can share too much on the 2011-12 plan because we're in the throes of working with the minister and the government on that. I think

it would be premature to start talking about allocation numbers or growth figures.

M^me^ France Gélinas: No; I'm not interested in the end result. I'm more interested in the process as to how we get there. What is the process for getting to a decision?

Mr. Saäd Rafi: Perhaps I'll start by saying that generally, we do zero-base budgeting. Based on that premise and that starting point, we have to examine what the potential allocation will be against the province's fiscal framework. We look at that across five very large sectors of health funding of which, within that, there might be dozens of lines of funding under each—under hospital funding, under community-based funding, under public health and emergency funding as well.

We have to then build up what is possible under a population-based assessment model for hospitals' growth funding and then look at, as you referred to in your previous question, other elements beyond the growth number. As you referenced, last year was 1.5%. What is some continued funding in the area of wait times? What is some continued funding in the areas of emergency department changes or pay-for-performance activities? Then that is put into an overall budget, which is, today, at $44.5 billion, to try to see what the next fiscal framework can accommodate. In concert with the minister, the Ministry of Finance and the Ministry of Infrastructure, that then gives us a sense of whether those five larger buckets will have any room whatsoever in which to provide increases, if any, or hold the line, if necessary. I suspect the latter will be more prevalent given the fiscal situation the province finds itself in.

That's a rudimentary approach to our budgeting that doesn't do it justice.

The Chair (Mr. Garfield Dunlop): Thank you very much, Deputy. We'll now go to the government members. Mr. McNeely?

Mr. Phil McNeely: Minister, thank you for being here.

I just want to get on the record a little bit about my past background as consulting engineer. They seem to be thrown into another group these last few days, so I just wanted to say what a good job the consulting engineers do in our province, and architects, environmentalists, environmental engineers and planners, how much we depend on them. I wanted to say that. I spent 35 years as a consulting engineer and I'm very proud of the work that all consultants do. We do have some beautiful facilities that are a result of those professionals.

I would like to get into the funding. I was just looking at the per capita health spending in Ontario. From 1992, 1993 and 1994, there was actually a decline in per capita health spending in Ontario. In 1995, 1996, 1997 and 1998, it was flatlined again. Those are the years that caused a lot of disruption in our health care system.

I would suggest that that was the time that lobbyists came up in prominence in this province, because you had to have a lobbyist to keep your hospital open. We had that with—the Grace we lost, the Riverside we lost; we were going to lose the cardiac unit at CHEO and we were going to lose the Montfort Hospital. We had SOS Montfort. It was an historic operation to keep that hospital open. Lobbyists were really prominent in that day to keep your hospitals open.

I'd really like to make the point that these are different days. When you hear the issues that have come from the other side, they're basically problems with the health system today. I agree with you entirely, Minister. When I took over as a freshman MPP in 2003, I would get calls about family doctors; they actually called me Dr. Phil. This is true: "If you can't find a doctor, phone Dr. Phil."

I went through that period and I'm very pleased to say that where we are today is so much better. We reinvested not only in infrastructure in many ways, but we reinvested in the health system. I was briefed on the excellent care for all strategy. What you're doing generally I think is just wonderful for the health care system, and it's coming a long way.

One of the areas we had problems with was sourcing IT. I'm glad to see that you now have IT Source, a modern, mobile workforce of OPS staff who can be deployed to IT projects across the government. As a consulting engineer, that was one of the most difficult things that I ran into—trying to figure out what you needed, and you had all these people telling you. When I went to the city of Ottawa as a councillor, we brought in the SAP project, which was to control all salaries—a huge project, $40 million—and it gave us trouble. If you review the IT projects from the beginning, I think what you've done with IT Source is exactly what had to be done so that you can properly scope the projects now with your in-house staff, define the expertise you need, estimate the time requirements, describe the deliverables, estimate the costs and monitor the in-house staff or consultants you hire.

I think that is wonderful. That has to be taken out to hospitals; that has to be taken out to the LHINs. Once you get into a consultation with a major IT project, at that time it's very difficult to make any changes, to change consultants even, and so this in-house expertise is wonderful.

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You mentioned in your speech the shortage of doctors in our communities. Since 2003—and they came in sort of late—I've got two new family health teams that are just up and running, one that has been running and doing a great job and two others that are starting, and this is just great, to expand the capacity of our doctors to do so much more work.

We have a million new patients in Ontario who are connected with family doctors, so that is essential. I know I got into problems switching from a Toronto doctor to one at home, summertime problem, and so there's still more to do.

But I would just like you to go over the access to family doctors and where the province is now.

Hon. Deborah Matthews: Thank you very much for that question. I first want to say that consultants are really

an important part of our health care system, and I know that there are some who have perhaps misinterpreted the legislation that we have recently gone forward with to somehow suggest that we don't support the use of consultants. That simply isn't so. What we are absolutely determined to do is ensure that consultants are properly procured and that once they are working on a project, there is appropriate oversight of those consultants. So you can pass on to your consulting engineer friends that we value the work of consultants. We just think it's important that appropriate oversight and appropriate procurement rules be followed.

The access to primary care, I have to say, was—there were two issues, and I'd have trouble saying which one was more prevalent when we were first elected in 2003. The two are access to primary care and wait times, that people were waiting unbelievably long periods of time for surgery they needed. And when we took over in 2003, first of all, we started to measure both of those and then we started to make strategic investments to address those problems.

Access to primary care: Of course, we know if people don't have primary care access, they use our emergency departments, and that's where they show up. They don't get the continuity of care that they need. They have to repeat their story every time they go into an emergency department or a walk-in clinic. The physician there doesn't know the history of the patient. There's no continuity of care. They don't know what medications they are on there. There is so much information they don't have. So we attached a very high priority to getting more Ontarians attached to primary health care providers.

George Smitherman used to say, when he was trying to explain why this was a stubborn problem, "You know, you can't make a doc as fast as you make a pizza." I don't know if you remember him saying that. He's absolutely right. So to have attached a million Ontarians in a period of seven years is an astonishing accomplishment, given how long it takes to train a doctor. It really did require a multi-pronged approach to be able to get 2,900 more physicians working today than when we took office: 2,900 more physicians serving a million more patients. We have more specialists as well.

So how did we do it? We expanded medical schools. We built a whole new medical school. We added 160 first-year spaces and we're committed to adding 100 more. We increased residency spots for family physicians, and now we're increasing residency spots for specialists. I just announced 75 new residency spots for specialists. We've enormously expanded the number of international medical graduates and more than doubled the number of IMGs who are getting residency spots every year.

We've reversed the brain drain. We used to hear about doctors moving south of the border, and I'm really proud that we've reversed that brain drain. We now have more doctors moving from the States into Ontario than the other way around.

The other thing we did is, by building our family health teams and supporting physicians with so many more allied health professionals, we're actually increasing the number of patients that any one doctor can see because they've got access to nurse practitioners, nurses, social workers and so on, so the doctors' time is spent doing the things that only doctors can do, and other allied health professionals are doing other things as well. The reality is that those allied health professionals actually do a better job than the doctors in some of those areas. If you need counselling, it's way better that you talk to a trained counsellor than to a doctor who may not have that specialty or may not have that time.

We've also launched forward on nurse practitioner-led clinics. We're just at the beginning of this, but it's a very exciting opportunity to increase access to primary health care.

We've got a million more Ontarians attached. We have about 94% of Ontarians now attached to primary health care. We've made a special effort to attach people with complex health conditions, vulnerable patients. We're really fast-tracking them through the Health Care Connect program. If someone enrols in Health Care Connect and they've got a complex health condition, we get them attached to primary care as quickly as we can. If you've got diabetes, we want you to have that primary health care because we know it's actually way better for the patient. It's also way better for the system, because if people don't have access to primary health care, they don't get that early diagnosis or the early treatment and it waits until it's gotten to a stage where they need much more expensive and much more invasive treatment.

Focusing on the front end, focusing on prevention, attaching people to primary care has been a very, very high priority for this government. As we talked about earlier, there still are parts of the province where we don't have the problem solved, but we have solved the problem in some parts of this province and we're determined to improve access for all Ontarians. Now we know where the problems are and we can make strategic investments to improve access to care there as well.

People really don't ask a lot of their government, but what they do ask is that they get the health care they need when they need it as close to home as possible. For many people, really the only interaction they have with the provincial government is the health care system.

Getting people access to primary health care is our job. When we said in our first mandate that we were going to attach 500,000 people to primary health care in the first four years, there were a lot of people who said, "You can't do that. It's just impossible," but we did it.

Then, in 2007, we made another commitment for the next four years that we would attach another 500,000 people, and we have done that a year ahead of schedule. So we're really making good progress.

I think the future of our health care system depends on us making those early investments, getting people the care they need as early as possible, having that continuity of care, having those regular tests done and getting that

primary health care. I just say that we've made extraordinary progress on that front and I'm really proud of it.

Mr. Phil McNeely: I agree with the direction we've been going in. You can't manage what you can't measure. I think that's been so important with the wait times for procedures and the wait times in emergencies. With the excellent care for all strategy, you're taking that measurement to another level, I believe.

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Making hospitals responsive, or having their compensation not on a historical basis but on so many procedures done, if you could just touch on that for a minute.

Hon. Deborah Matthews: Sure.

The Chair (Mr. Garfield Dunlop): You have five minutes left in this round, Minister.

Hon. Deborah Matthews: Okay. The Excellent Care for All Act has really been celebrated and embraced by health care providers across the province. I'm not sure that we, as MPPs, actually understood the impact that it would have on the system. I have the opportunity to talk to people from across the province, and they are very excited about this new responsibility that they will have, and that is to start focusing on quality of care.

We asked our hospital boards to take responsibility for fiscal matters for a number of different—they have a number of different responsibilities, and now they have a new one: It's quality of care.

What we are going to do is develop quality metrics that hospitals right across this province will report on. They will see how they are doing compared to other hospitals. They will be required to have quality improvement committees in the hospital. On those quality improvement committees, we'll have nurses, doctors and others, who are really focused on how we improve the quality in this particular hospital. Then every year, they'll come up with quality improvement plans, and the compensation of the executives will be tied to achieving those quality indicators.

It's so important, because we know that poor-quality care is actually very expensive care. Poor-quality care means that people get pressure ulcers that they didn't have to have. It means that people are discharged from the hospital without proper support on discharge, and they end up being readmitted into the hospital. It means that infections can happen in hospitals.

None of this has to happen. We know how to deliver high-quality care. Now we have to actually get to work and do it. We know how to do it; now we're going to measure it.

I tell you, when we start measuring and publicly reporting, there will be some bad news there, because once you start measuring, you do sometimes find—in fact, you always find—bad news. But that's the point of measuring. That's the point of publicly reporting: so that you can see where you're falling short and you can see where you can make improvements.

We're starting with hospitals when it comes to quality, but we're not going to finish with hospitals. We're going to spread this focus on quality right across the health care sector.

I do have to say that our long-term-care sector actually is showing us how to do it. They are leading the way when it comes to quality indicators. I am enormously proud of our long-term-care sector for what they have done when it comes to quality. They have a patient-first initiative that is bringing down rates of falls, pressure ulcers and depression amongst the residents of long-term-care homes because now they know what they're looking for and they're measuring it, and they're having early interventions to make sure that people are getting the care that they need to live full lives in our long-term-care homes.

I'm excited about excellent care for all. It's going to be a challenge; we know that. But it will improve health care; it will improve the quality of health care and it does mean that our system will be significantly stronger.

The other really important piece of excellent care for all is, we're really turning our focus to the evidence. We know that while we like to think in health care that everything we do is evidence-based, in fact we do a lot of things that are not evidence-based. If you actually take the time to look at the research, to understand the evidence and then change your practice to comply with the evidence—we, again, are funding things that we don't need to fund, because they don't improve patient outcomes. We will also find that there are things we could do that will require more funding to improve the quality, and we will be able to make those strategic investments there.

The Chair (Mr. Garfield Dunlop): That pretty well cleans it up. We've just got 20 seconds. Anybody have a quick comment to make? Mr. Levac.

Mr. Dave Levac: Thanks to the minister and all the ministry staff for assisting us with answering all these questions. I think that they deserve a lot of kudos for putting themselves out there to try to give us all of that information in a timely way.

The Chair (Mr. Garfield Dunlop): I notice that quite a few people didn't show up.

Mr. Dave Levac: That's what I was looking at. I was looking at it and going, "Holy mackerel."

The Chair (Mr. Garfield Dunlop): Anyhow, they're available, I take it.

With that, I appreciate that very much. To the minister, thank you so much; deputy, all the minister's staff.

We'll adjourn this meeting and we will reconvene on November 16 at 9 o'clock in the morning here. With that, we'll adjourn the meeting. Thank you very much, everyone.

The committee adjourned at 1808.

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