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Tuesday 16 November 2010

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Mardi 16 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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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON ESTIMATES

COMITÉ PERMANENT DES BUDGETS DES DÉPENSES

Tuesday 16 November 2010

Mardi 16 novembre 2010

The committee met at 0903 in room 151.

MINISTRY OF HEALTH AND LONG-TERM CARE

The Chair (Mr. Garfield Dunlop): Good morning, everyone. I'd like to welcome everybody back to the committee, particularly Minister Matthews and all the staff of the Ministry of Health and Long-Term Care.

We are now resuming consideration of the estimates of the Ministry of Health and Long-Term Care, vote 1401. There is a total of three hours and 47 minutes remaining, so we should be able to clean up health today.

When the committee last met, the government caucus members had finished their 20-minute turn. We will now start the next round of questioning with the official opposition party for 20 minutes, followed in turn by the third party and then the government side for their next rounds.

I recognize the official opposition. You have 20 minutes, and we will try to go to 10:20 today, just to give us 10 minutes to get up to the House for question period. Okay?

Thank you very much. Mr. Clark, can you start?

Mr. Steve Clark: Yes, I can. Just before I do: Minister, good morning. You had mentioned that you had had some additional information on one of my questions regarding consulting contracts. Is this the time where you're going to provide that information? Just asking.

Hon. Deborah Matthews: We'll be getting information due by the end of the day today.

Mr. Steve Clark: I am going to be splitting my time with my honourable colleague beside me. I do want to ask a few questions first, sort of as a follow-up to some questions we had at our last sitting.

Minister, I just want to go back to page 12 of the Auditor General's report where they talk about the two cases of higher-priced consultants that were given preferential treatment in the procurement process. In one case, as I'm sure you're aware from the report, one of the consultants was the highest of 12 bidders. I guess my initial question is really to ask you to explain how the ministry broke the rules when previously you and the Premier had indicated that it wouldn't happen again.

Hon. Deborah Matthews: I'm going to ask my deputy to respond to this one.

Mr. Saäd Rafi: I would say that what are called "delegated authorities" that were in place at the time allowed executives in the ministry to make decisions at higher approval amounts. Regrettably, I think some poor choices were made by those individuals, as identified by the auditor in his report.

Subsequent to the minister's arrival in the ministry and my own shortly after that, we have moved, I think, fairly expeditiously to try and close down as many of those opportunities as possible, meaning that we have reduced the level of delegated authority for executives in the ministry. We have put in place a check-and-balance approach that requires another assistant deputy minister, preferably the chief administrative officer, to approve, first, the intent of the RFP and then how it is procured, with a group in the ministry that works with those executives, as well as putting on additional training.

To the greatest extent possible, we've tried, on a go-forward basis, to prevent these kinds of issues happening—

Mr. Steve Clark: With all due respect, I've heard about this double-checking contract release. I can appreciate you talking about moving forward. I want to know how, after the minister and the Premier made assurances that this type of contract wouldn't happen again, we are sitting here with an Auditor General's report and more discussion about what's going forward. I want to know what happened, and I would like the minister to address that, please.

Mr. Saäd Rafi: The only thing I can tell you—because I wasn't at the ministry at the time, so regrettably—

Mr. Steve Clark: No. With all due respect, someone has to take accountability for how, after this wasn't supposed to happen again, it did. I can appreciate moving forward. I want to know how this happened. I think the people of Ontario want to know how it happened.

Mr. Saäd Rafi: What I'm trying to say is that prior to the directives that were changed by the government, these actions took place. They were a function of the choices of people who had the ability to make those choices, and unfortunately they've made the—

Mr. Steve Clark: But, Deputy Minister, $819,000, the highest of 12 bids—we're not talking about pocket change here. This is significant. For us to be sitting here with this happening a second time is unbelievable, and I just can't believe that someone isn't going to come

forward and give us the straight goods. I just don't understand that. Help me, Minister.

Hon. Deborah Matthews: Let's just back up a bit. There have been protocols in place for a long, long time that are simply not acceptable today. I think it's safe to say that under governments of all stripes there were procurement protocols in place that don't withstand the test of the light of day—

Mr. Steve Clark: But, Minister—

Hon. Deborah Matthews: Excuse me; if you—

Mr. Steve Clark: But we had eHealth, and it wasn't supposed to happen again.

Hon. Deborah Matthews: Chair, may I answer?

The Chair (Mr. Garfield Dunlop): Okay. Take a couple of minutes to answer. Then we'll get back to you, Mr. Clark.

Mr. Steve Clark: It wasn't supposed to happen again, Mr. Chair.

The Chair (Mr. Garfield Dunlop): Let the minister—

Mrs. Liz Sandals: Let her explain.

The Chair (Mr. Garfield Dunlop): We'll handle this. Go ahead, Minister.

Hon. Deborah Matthews: There have been protocols in place that have, as I said, gone under governments of all stripes. Ours is the government that has put an end to this kind of protocol. I think it's worth listening to the deputy about what protocols have been put in place prior to the release of this Auditor General's report that will prevent that from happening again.

I also think it's important to note that price is not the only criterion for selection of a consultant. There are other factors that go into the decision.

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

0910

Mr. Steve Clark: Minister, you talk about "governments of all stripes." I'm talking about you and the Premier, after eHealth, making a pledge that this wouldn't happen again, and we're sitting here again talking about the same type of contracts. Now you're saying it won't happen a third time because you're double-checking a contract release. Something went wrong after you promised it wasn't going to happen again. Talking about moving forward doesn't answer the question.

Hon. Deborah Matthews: I am not going to sit here and defend what happened. I think that the fact that the auditor went in at our request to look at the issue of procurement of consultants is a testament to our desire to continue to clean up protocols that are not acceptable.

I think it's also worth noting that the auditor himself, in the report, notes that there has been a significant change since the change in procurement rules has taken place. I will try to find that quote for you, but I think the auditor himself points out that significant improvements have been made.

Mr. Steve Clark: Minister, you can read the report. I'll read a quote from page 13: "The consultant's statement of work, signed by the ministry, listed project deliverables but had no breakdown of how the contract price had been arrived at...." It later says, "Nor could the ministry justify the project's cost...."

There were glaring things that were put in place after eHealth, after assurances that this type of thing wouldn't happen again, yet on your watch, it did. It's unbelievable, and I can't understand why all you want to talk about is moving forward. It makes no sense to me whatsoever.

Hon. Deborah Matthews: Let me try again. The experience with eHealth taught us a number of lessons and precipitated significant changes in the ministry. Those are changes that are now entrenched in the culture of the ministry. The deputy has spoken about the checks and balances that are now in place that were not in place before. That will prevent this from happening in the future.

I am not, as I said, going to defend what happened. It is my responsibility to put in place the protocols to ensure that it does not happen again.

The auditor himself did note that things are significantly improved. As you'll recall, his report spans the time prior to the procurement changes and after the procurement changes, so it's difficult to pull out of the examples of what was before the change and what was after the change. We have significantly changed the procurement protocols within the ministry. What we are doing in our legislation is, of course, taking the advice of the Auditor General and extending it to the broader public sector.

I will read from the auditor's report on page 12; I think you have that page open. He says, "Our review of a sample of consulting-services engagements from April 2009 to February 2010 confirmed that, for the most part, the ministry was complying with requirements."

I take the auditor's opinion as a very valid opinion. He investigated thoroughly. This is the conclusion the auditor came to, and we have put in place some protocols that will prevent this from happening in the future.

I have to say that I think it is significant to note that the auditor did go in at our request to give us our best advice. I actually think that is something we should all take pride in: that we are open; we are transparent; we are accountable. That means shining a light where the light had not been shone before. When your party was in power, there was no light being shone. There is now a light being shone. I think it's incumbent upon us in government to actually be prepared to see where we can make improvements. As long as we have an Auditor General, there will always be advice on how to improve, and what we're doing is acting on what the auditor said.

Mr. Steve Clark: But your answer is the same now as it was after eHealth: "It's not going to happen again." It's the same answer. I'll go back. You say "significant to note." It's significant to note on page 12 that in two cases, higher-priced consultants were given preferential treatment in the procurement process. You said that it wasn't going to happen again, and it did. That's what I'm talking about.

Hon. Deborah Matthews: So, in fairness, what I think I'm going to ask the deputy to do is to repeat what

changes we have put in place in the ministry to ensure that this will not happen again.

Mr. Steve Clark: I heard it the third time. I understand "double-checking contract release; it won't happen again," but that's what you said the first time. How do you expect a LHIN or a hospital or eHealth or Cancer Care Ontario to follow the rules when your own ministry didn't follow the rules?

Hon. Deborah Matthews: With respect, we are following the rules that are in place today. We put in place those rules and we are following those rules. We have very high standards for our agencies. They understand how seriously we take this.

Mr. Steve Clark: I thought you were putting high standards in after eHealth, and we're sitting here with the same thing, the same discussion.

Hon. Deborah Matthews: The protocols we have put in place are as a result of eHealth, so I think there's a little chronology issue here. So we've learned lessons from eHealth, we've put in place protocols, the Auditor General himself acknowledges that those protocols are working, and we're moving forward.

The Chair (Mr. Garfield Dunlop): Mr. Arnott, have you got a question?

Mr. Ted Arnott: I do.

The Chair (Mr. Garfield Dunlop): There are seven minutes remaining in this round.

Mr. Ted Arnott: I very much appreciate this opportunity to ask questions of the Minister of Health and have the deputy minister here, as well as Ms. Sandals, the member for Guelph, and the member for Oakville, Mr. Flynn. I know that they're interested in the hospital proposals in Wellington–Halton Hills as well. Unfortunately, Mr. Flynn didn't see fit to support my resolution on October 22, but at the same time, I know that because he works with Halton Healthcare Services, he would perhaps want to reconsider that going forward.

I wanted to ask you, Minister, if you've had the opportunity to be briefed by ministry staff on the hospital proposals that are being put forward by the Groves Memorial Community Hospital in Fergus, as well as the Georgetown Hospital in Georgetown, which is part of Halton Healthcare Services.

Hon. Deborah Matthews: Yes, I have. What I can tell you is that in the Groves situation there is a plan for a new facility that has been submitted to us, and I'm aware of that. When it comes to Georgetown, I understand that that proposal actually has not yet been submitted. That's my understanding. Maybe you can update me if that's not the case.

Mr. Ted Arnott: But you would be aware that a meeting took place in your boardroom—I hope that your staff would have informed you of that—in late August, with senior ministry staff, where the hospital representatives from Georgetown and Halton Healthcare Services gave a presentation to your senior ministry staff to inform them of the need for a small capital project to accommodate our new CT scanner that the government has approved, as well as renovations to the emergency room.

Yes, I'm pleased that you have had at least an opportunity to hear something about the projects and that we've had the opportunity, you and I, to discuss them privately during quiet moments in the Legislature.

I just wanted to ask you what you could advise my communities with respect to those projects going forward. What is the likelihood of their approval, and when would we expect to hear something from the ministry in response to those project needs that have been identified?

Hon. Deborah Matthews: As you would be aware, we have embarked on the largest health infrastructure renewal program ever in the history of Ontario. Many of your colleagues in caucus have seen hospitals built as a result of that.

We inherited a disgraceful deficit when it came to hospital infrastructure. We did turn our attention—we had a first five-year ReNew Ontario infrastructure plan. As you can imagine, there was tremendous demand for the resources that we allocated to capital. We are now working with the Minister of Infrastructure on a 10-year capital plan. We are taking all of the proposals and looking very hard at what we can do. You would be aware that the fiscal reality means that there is significant competition for those resources, and we are doing the very, very best we can to come up with a plan that will meet the needs of Ontarians.

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I do have to say, though, that because the deficit that was created was so enormous, we're still playing catch-up. We take this very seriously. We know that there are capacity issues. We know there are safety issues. We know that there are growing communities that don't have access to the care they need because of the population growth in those areas. We still have buildings that are very old.

We know that delivering health care is significantly different now than it was. There's a lot more done on an outpatient basis. The equipment is larger. There's a lot more in an operating room, for example, than there used to be. There's a lot more equipment, a lot more people.

We know that we still have, despite an extraordinary investment in infrastructure—18 brand new hospitals and 117 major capital projects across this province. We know there's still more to do, and we know that you're anxious to see the ones in your riding completed.

Mr. Ted Arnott: And $2.3 billion, apparently, spent last year on the total infrastructure investments on hospitals, according to the budget documents, and this coming year it's $2.065 billion. That's, to some degree, fuelling the expectation in our communities. There's a lot of money being spent, and we would hope to find out where we are on the list of—

Hon. Deborah Matthews: There is a lot of money being spent, but I have to tell you, when you line that up against the need—we're making headway, we're making up for lost time, but I will tell you, this will cost a significant amount of money. Then, of course, once you build a new hospital, very often you've expanded services, and there's a need for more operating money as

well. We're really focused on ensuring that people have access to infrastructure, but I tell you, we cannot move forward on infrastructure if we don't have the resources to do it.

I know that you voted against the last infrastructure plan, the first five-year plan, so I'm asking you if you will support the next one as we continue to rebuild infrastructure in the province.

Mr. Ted Arnott: Well, I would have voted against your budget because I sit in opposition. But at the same time, I appreciate your explanation.

I understand that you're probably going to be coming to Guelph this Friday—

Hon. Deborah Matthews: Yes, I am.

Mr. Ted Arnott: —to participate in the opening of the north wing of St. Joseph's Health Centre. I would like to publicly extend to you an invitation to also visit the Groves Memorial Community Hospital as well as the Georgetown Hospital, if you have the opportunity, if you have some free time during the course of that day. You may have other commitments—I don't know—but certainly you would be welcome to visit us.

Hon. Deborah Matthews: Thank you very much.

Mr. Ted Arnott: If you're not able to visit us, I'd like to ask you at this time if you would be willing to meet personally with hospital representatives from the Groves Memorial Community Hospital and the Georgetown Hospital, at some point before Christmas, so that they can have the chance to explain to you what their needs are and so that you'll have an opportunity to hear first-hand from them what it is they would like to see you do.

Hon. Deborah Matthews: I appreciate the invitation, and I will see what my schedule will allow.

The Chair (Mr. Garfield Dunlop): And that's the time we have for the official opposition. We'll now go to the third party. Mr. Prue.

Mr. Michael Prue: Madam Minister, good morning again.

Hon. Deborah Matthews: Good morning again.

Mr. Michael Prue: You started off by making a statement to the first questioner that your government is open and transparent. I know the government likes to say that's true, but the question I have comes about because we have consistently, in the NDP, been forced to file freedom-of-information requests around a great number of things that we're trying to find out, and it's not very open and transparent to us on some of the facts that we're looking for.

Particularly, we are trying to find out about the levels of care: hours actually delivered as opposed to hours paid, broken down by sub-sector—municipal, charitable, not-for-profit, for-profit; and by classification—PSWs, RPNs, RNs, nurses, management. Why is the government so reluctant to release this information any other way except by freedom of information?

Hon. Deborah Matthews: I think France Gélinas asked similar questions, and we are working to get that information.

Sometimes there are requests for information that are asking for information in a format that we don't actually—we don't have those records. We have to create the information. It takes time, it takes services. We do our best to get information to you under freedom of information, and I know you'd like it faster, but it isn't always possible to do that.

I think the freedom-of-information legislation is there for a reason. It's designed to protect third parties, for example.

We do our best to get the information to you, and we'll continue to endeavour to get it for you in a timely manner.

Mr. Michael Prue: I have some difficulty with the answer because in the United States freedom of information is not considered anything to do with third parties or trying to keep things private. It's published online literally in every state. This is not breaking new ground; this is Ontario being behind the pack in being open and accessible. This is done in other jurisdictions on this continent with great regularity. I'm wondering why the Ontario government has not been willing to do this in the past and when we can expect that to change.

Hon. Deborah Matthews: When it comes to transparency and what's posted online, Ontario leads the way when it comes to reporting wait times. All of the procedures now are online. When it comes to reporting infection rates in hospitals, it's publicly available. I think that people from Ontario are actually invited to go elsewhere to talk about our publicly reported results when it comes to health care. So there are parts where we lead.

I'm asking you if you would repeat what exactly it is that you are looking for.

Mr. Michael Prue: What we have been forced to get through freedom-of-information requests is what levels of care are actually delivered as opposed to those hours that are paid, broken down by the subsectors: municipal, charitable, not-for-profit, and for-profit. Also, we're looking at it by major classification, like who delivers these hours of care: personal service workers, registered nurses, nurses, RPNs, management. That's what we're trying to find out: hours of care throughout the long-term-care system. Your predecessor, Mr. Smitherman, openly wept in the Legislature, talking about the levels of care and a huge commitment to increase them. What we're trying to find out is how much the government has done along this and what levels are actually being provided so we can monitor and make sure you're doing what was promised.

Hon. Deborah Matthews: What's very, very important to us are the outcomes and how people are doing. The Ontario Health Quality Council, of course, is now reporting on long-term-care outcome indicators.

We know that when we start to report on indicators, care improves and outcomes improve. When we started to report on C. difficile rates, for example, we saw those rates decline because people working in hospitals saw how they were doing compared to other hospitals and they improved their practices. We now know that in long-term care, once we start reporting incidents of pressure

ulcers, for example, those rates start to decline because professionals in those long-term-care homes know how to prevent pressure ulcers. So we're giving them the tools.

What's very important to us is how patients in long-term care are doing. Actually, in long-term care we're moving to outcome-based quality reporting, so that we're looking at falls, at how people are doing, how their health is, how their nutrition levels are, what their activity levels are. Once we start tracking those outcome indicators, we're seeing, I would say, nothing short of remarkable results. We're seeing incidents of depression, for example, declining because people are paying attention to the early signs of depression early on and taking those appropriate steps.

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We really are moving forward on improving quality, not just in long-term care, not just in hospitals—that's where our focus is now—but our Excellent Care for All legislation means that we are going to be publicly reporting on quality indicators; hospitals across the province are going to be able to compare how they're doing compared to other hospitals. It will drive change, and it's change for patients that matters most to us.

Mr. Michael Prue: I understand about the hospitals; I'm trying to focus on long-term-care facilities.

The Toronto Star today is reporting again on a horrendous situation where people who are in long-term-care homes are potentially losing great sums of money. It's the same place they reported on where the gentleman subsequently died lying in his own feces on the floor.

Ordinary people want to look at these indicators that we have to get through freedom of information to know what kind of care is being provided in each and every home—whether there is a difference between the not-for-profit and the profit homes; whether there is care provided by nurses or PSWs or someone else. They want to know that kind of information and they want it posted. Surely families are entitled to know, before they put a parent or a loved one into those places, what level of care they can expect and whether or not there's a better level of care in one type of institution versus another. Why won't the government publish this?

Hon. Deborah Matthews: I think, first of all, I need to clarify that in the article in the paper that you're referring to today, it was not a long-term-care home; it was a retirement home.

Mr. Michael Prue: Right; excuse me, it was.

Hon. Deborah Matthews: And we are now moving to regulate retirement homes. Never before have retirement homes been regulated—

Mr. Michael Prue: I'm sorry. I shouldn't have used that as the example. You're right.

Hon. Deborah Matthews: Okay. So that was a retirement home.

We are reporting on outcomes. The long-term-care sector is leading the way. The Residents First initiatives are really making a difference for people, and some of them are now reporting. Increasingly, more and more are reporting.

I attended a conference several weeks ago. I think there were over 1,000 people there from long-term-care homes across the province wanting to be part of the next wave of the Residents First program. They are absolutely convinced they can provide better care for their residents. They're very excited about the tools that are provided to those homes that are now participating.

The Ontario Health Quality Council is driving this change in long-term care for the very reasons that you have mentioned. When people go into long-term care, their family members need to have confidence that those residents are getting the very best possible care. We now know how to measure quality of care in long-term care. We are measuring outcomes. We used to have a system where we measured inputs as opposed to outcomes. We're really focusing now on outcomes. How are people doing? How's their health? How's their physical health? How's their mental health? What is their level of involvement in social programs and so on within the home? We've got a lot to be proud of when it comes to quality indicators in our long-term-care homes.

I know you want to divide the homes into their governance structure and so on. That is not how we collect information. As far as we're concerned, every long-term-care home in the province has to be held to the same very high standards. It doesn't matter what their governance model is; what matters is people who are living there get the care they need. That's what matters to us. That's how we collect the information.

So to go back to your question about what's posted and what's not, what we're publicly reporting on now are quality outcome indicators.

Mr. Michael Prue: And you're right, because when we went through freedom of information, the data released to us in the report from June 2009 for the period to December 2007 show that residents in for-profit nursing homes have consistently received, on average, the least amount of care, though ministry reports show that such residents, on average, have the highest care needs. We're very concerned. You may not be concerned about the governance model, but we are concerned that people in for-profit homes are not getting the same level of care as in not-for-profit homes.

What inquiries has the ministry undertaken to determine why this inconsistency exists? You don't care about the governance model, obviously, but why is there an inconsistency in care between for-profit and not-for-profit, with one being demonstrably worse, using the government's own statistics?

Hon. Deborah Matthews: I think it's fair to say that different researchers have come to different conclusions on that issue. I wonder if you're advocating that we move away from a mixed model when it comes to long-term care, that your position is that all long-term-care homes should be not-for-profits. That would be enormously disruptive to the long-term-care sector.

What we're trying to do is expand capacity. We're also trying to improve quality. As I said earlier, what's vitally important is high-quality care based on outcomes for patients. That's what we need to follow, because at the end of the day, that's what matters. What matters is how people are doing and the kind of care they are getting. Those homes that are not providing high-quality care will have no choice but to improve the quality.

I expect that you're familiar with Shirlee Sharkey's report on long-term care. Her advice, and the advice of her experts, was that the focus on outcomes was the way to go, because—as you well know—focusing on inputs doesn't tell the whole story. So we think the most improvement can be made by focusing on outcomes. That's what matters to people.

Mr. Michael Prue: We think that the most improvement can be made not by shutting down the for-profits, but by making sure that the government halts further expansion until this bridge is gapped, so that the for-profits know that they have to measure up to the same standards as not-for-profits. All of our residents, no matter where they end up in their old age, deserve the same level of care, and the level of care in the for-profit sector, according to government statistics, does not measure up. We wonder why the government is expanding into that sector when the outcomes are not as favourable as if you went the other way.

I don't mind the for-profit sector. I'm not going to rail against them here, but I am going to say that if they're not delivering the same quality of service, why are we spending money to expand them?

Hon. Deborah Matthews: I couldn't agree with you more that all long-term-care homes in the province, regardless of their governance model, should be held to the very highest standard. That is exactly what we are doing. As we now measure quality on the basis of outcomes, we will be able to make changes where necessary.

I'm going to actually ask the deputy to speak to the issue. He's got some numbers here that I'm sure you'd be interested in.

Mr. Saäd Rafi: I'm not sure what information you're referencing, but I think in the responses to the questions last year, we did table the number of paid hours by type of professional, by type of home—charitable, municipal, nursing home and nursing home for-profit—and that information appears to indicate that there's a 0.01 hour per day total difference, or 0.1, depending on which type of category you look at.

In addition to the quality point that's been made, I think the annual inspection is also something that has to be taken into consideration, with respect to what aspects each home is obligated to provide. There is no difference across models as to what their substantive quality requirements are, in terms of care management, care provision and facility management in terms of infection control and so on. So you have me at a bit of a disadvantage if you're quoting those numbers, but I was just reflecting on the information that was provided from the questions from last year.

0940

Mr. Michael Prue: But again, what we are looking at is actual care levels, not the hours paid, because we think that that's somewhat different.

In any event, what steps is the government taking to ensure that care levels at each home are increased at least proportionally to average increases in resident care need? The data that we have from 2004 to 2007 show that care hours did not increase as much as increase in care needs.

Hon. Deborah Matthews: I would be more than happy to take a look at what it is you're referring to, because I'm not quite sure what it is.

Mr. Michael Prue: I will have our researchers give that to you.

Hon. Deborah Matthews: That would be excellent.

We've actually come a long way when it comes to determining the acuity levels of people in long-term-care homes. There's now a standardized assessment tool to determine the level of needs of any individual patient or resident in a long-term-care home. That assessment is done, and funding does depend on that level of care.

What we do know is that as we are increasingly successful in keeping people home as long as possible—because that very much is our focus right now, to increase the supports in the community so people can stay at home as long as they possibly can—that will have an impact on the long-term-care sector. Right now, we know that a significant number of people are in long-term care who don't really need to be there and who, with the right supports, could have stayed at home. Going forward, we want to support people in their home and, in some rare cases, bring people back home. There are examples of people moving from long-term care back into the community. As we strengthen our community supports, that also, of course, means that people in long-term-care homes will have greater needs, and we need to really keep on top of that to ensure that we respond accordingly.

Mr. Michael Prue: How much time do I have, Mr. Chair?

The Chair (Mr. Garfield Dunlop): You have just a little under two minutes.

Mr. Michael Prue: Okay. What is the current average wait time for admission to a long-term-care home from each of the different priority groups and how do these times compare to 12 months ago when we last asked these questions?

Hon. Deborah Matthews: We will endeavour to get you that information. As you know, the Ontario Health Quality Council does report, by LHIN I believe, on wait times, based on different levels of need, as I recall.

Mr. Michael Prue: Are the numbers going up or down?

Hon. Deborah Matthews: The numbers—

Mr. Michael Prue: The wait times, are they going up or down?

Hon. Deborah Matthews: The wait times are going up in most but not all LHINs, as I understand. That is why we're redoubling our efforts to keep people home as long as possible.

You know that we have a significant ALC challenge in our hospitals now where approximately 17% of our hospital acute care beds are occupied by people who should not be in hospital, who should be in the community, should be supported at home or should be in long-term care. That's an unacceptably high rate, and we're working very hard to get that rate down.

There's a lot of change right now happening in the system as we work hard to get the ALC rates down, which, of course, then impacts our emergency department wait times, and as we build community supports and increase capacity in long-term care.

Mr. Michael Prue: With respect, I've heard this same thing said by the government for as long as I've been here, which is nine years. I've heard these exact same things being said. What has the government done? This isn't a new phenomenon. Anybody who studies populations and changes and aging knows that this is happening and is going to increasingly happen with boomers as they get older. Why has the government been so slow to act on what everybody knows needs to be done?

The Chair (Mr. Garfield Dunlop): I think she'll have to respond in the next round, Mr. Prue.

Mr. Michael Prue: Jeez, I think that was a good question.

The Chair (Mr. Garfield Dunlop): It's a good question, and she can start out her round on that.

We'll go now to the government members. Mr. Flynn.

Mr. Kevin Daniel Flynn: Minister, in response to, I think it was, Mr. Clark's question you were answering, you were saying that if you were to look at the infrastructure deficit that was inherited at 2003, it was quite significant, and it probably didn't present itself any more strongly than in some of the growth areas. I think of the areas where I lived, perhaps in Oakville, Burlington, Milton: Those areas were experiencing huge population increases. I think a level of strategic management attempted to be brought to bear on this, and the system was designed organizationally to try to meet those needs in a way that was done in a systematic way.

In Oakville, in my own community, for example, we're in the latest stages of the RFP process, where we hope to see the award of a brand new hospital—built just outside my riding, I might note, in the member of the opposition's riding—but it certainly will serve my community, I think, in a way that should be done.

I've taken a tour of the Guelph hospital, for example, as chair of the Select Committee on Mental Health and Addictions. I was tremendously impressed with the emergency room department at Guelph General Hospital. I've taken a tour of Joe Brant hospital in Burlington on a number of occasions because some of my constituents actually use Joe Brant.

The Milton hospital, for example: I've taken quite a note of that as well because it's a neighbouring community. My 18 years on council gave me a sense that when that community went through the growth period it went through, there were going to be some substantial health care needs.

Some may use stunts and political theatre to get what they want. I think others have taken a different approach to securing the health needs for their province and have tried to do it in a systematic way that relates to demand and the needs. But what most people feel, I think, when they go to the hospital—one of the things where they interact with the local hospital or teaching hospital is when they're going in for surgery. That's one of the most important things, I think. That's where they look to their hospital as a place where they're going to get some serious or perhaps day surgery performed on them.

In the past, I know we didn't measure the wait times. I guess it was just a matter of trying to do the best you could. We've started to, as I understand it now, apply that metric to the provision of surgery for people. We've heard that Ontario now is starting to lead the country in the way that it approaches this and, in fact, in some of the results. There's more to be done. Still, obviously people want the shortest amount of wait time possible. When you go to the doctor and he or she tells you you need surgery, you want that done as soon as possible.

What things have you put in place that would drive down those wait times? What things do you think we're going to have to continue to do to continue to make the progress we're seeing in wait times?

Hon. Deborah Matthews: I think that one of the proudest achievements of our government has been our success in bringing down wait times. You might recall, back in 2003, that all elected people from all parties heard terrible stories about people waiting for surgery. I remember vividly a couple coming to my constituency office, an elderly couple. Clearly, they cared for one another and loved each other very much. They were both in tears and then, of course, I was in tears as well, listening to the story. The woman had been waiting for hip replacement surgery for two years. She was in agony. She was taking pain medication that was damaging her stomach, so now she had another set of problems related to her ability to eat. They were at their wits' ends because they couldn't get access to surgery in a way that was even remotely acceptable.

At that time, we did not measure wait times. What we have done as a government is, we started to measure wait times; we defined wait times. What we used to have was that every specialist had their own list, a paper-based list. We did not aggregate that list. We heard anecdotally about somebody having a longer list than somebody else, but it was all word of mouth. Now, what we have, we measure; we publicly report, by hospital. We started with five procedures; we now list all the surgical procedures and diagnostic testing procedures that are done. They are listed by hospital. So we have brought wait times down dramatically.

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I had a look just last week at the top 10 improvements, and Sudbury Regional Hospital has brought knee replacement surgery wait times down by 773 days. That's a two-year reduction in wait times for people who need that procedure in order to get on with their lives.

We've done it by making strategic investments. The only reason we've been able to bring those wait times down is by paying for more procedures, and that's exactly what we've done. People can now go online to ontario.ca/healthcareoptions. I actually would suggest everybody do that. You can see now the wait times for different procedures in your community, and you can compare to other communities. So if you want to go elsewhere, you can talk to your doctor and get a referral to a place that has a shorter wait time. This is very empowering for people. It gives them ownership over their health care.

We are continuing to bring down wait times, but we've actually met targets in almost all of the surgical areas in almost all of the LHINs. We still have challenges when it comes to diagnostic imaging, so we are continuing to make strategic investments to bring down those wait times.

What we've done in seven years is gone from knowing virtually nothing other than anecdotal information about wait times to now where we measure, we publicly report, and we make strategic investments to bring down those wait times down. We're continuing to monitor to see where we need to continue making strategic investments to bring them down, and, as I say, also giving people the ability to see what those wait times are, because they do vary across the province and people can get the care they need more quickly.

Mr. Kevin Daniel Flynn: I mentioned earlier how impressed I was when we did the visit to the Guelph hospital emergency room. I was really impressed, especially with the way they approach mental health issues, where you sort of go in the front door, and if it's a physical ailment, you turn left, and if it's a mental health issue, you turn right and you get the service you need fairly quickly. My own hospital in Oakville I think provides the best it can do when it comes to emergency room waits.

Often when there's a condition or an illness that's going to require surgery, there's a chance to plan for that: It's a symptom, it's a visit to the doctor, it's a visit to the specialist and then it's a plan for surgery. Emergency room visits come up out of the blue, hence their name: emergencies. It's somewhere you've got to get to quickly. Sometimes it's the only place you can get to quickly, and it's a part of your life that you haven't planned for. Often it becomes a source of the most frustration. People say, "I went to emergency the other day. I hadn't planned on going to emergency and I ended up spending four hours" or "I ended up spending six hours there."

In the past, I understand, we didn't measure that. In the past, it was just, you got in there, you got in line and the doctors and nurses did the best they could to triage you based on priority, based on your need, but there was a wide variation. Some emergency rooms seemed to have a good reputation; others seemed to have a very slow reputation. Sometimes that was maybe unfair, depending on the patient load in that geographic area, but it was something where, in the past, there was no measurement applied to it at all.

Is it possible to apply the same metric that you apply to surgeries to emergency room waits? If it is possible, how effective is that in us being able to understand whether that particular institution is doing the best it can in the provision of emergency services?

Hon. Deborah Matthews: We started our wait-time strategy with five procedures, and then we dramatically expanded the list. Then we turned our attention to emergency departments. The people in the health care sector tell us that that was a very brave thing to do, because the emergency department is where all of the problems in health care manifest themselves. Tackling emergency department wait times really does require us to look at the whole system of health care but that's what we did, and we set targets. Four hours is our target. We want 90% of people coming with relatively minor conditions to be in and out within four hours. More complex people, we want them in and out of the emergency department, whether it's back home or whether it's admitted to hospital, within eight hours. So we've set the targets. We've supported hospitals making significant changes to how they deal with the patient flow within emergency departments to really see some good results. We aren't at our target yet, but we are making significant progress toward our target. We've had an 8.3% improvement in time spent by those minor, uncomplicated patients. We've seen almost 20% improvement in the time spent for the more complicated cases. Now, as of July, we have 83% of complex people meeting that eight-hour target and 87% of the minor or uncomplicated meeting the four-hour target.

I want to be really clear: We actually measure length of stay in emergency departments. It's from the time you arrive to the time you leave and, of course, that includes all the treatment time. It's not really how much you're waiting for care; it's how much that whole period of care takes.

We're seeing significant improvements. Many of the hospitals have gone through ED PIP, the process improvement plan, where the people who work in the emergency departments are actually tasked with easing the flow of patients so they get their diagnostic results more quickly. A number of different techniques are being used in different hospitals but it's showing results. I think you're absolutely right. People want to know how long they should expect to wait.

Having said that, emergency departments are there to serve those real emergencies. Part of what we are doing is actually encouraging people to go elsewhere, not to the emergency department unless they need to go to the emergency department. Part of this website, ontario.ca/healthcareoptions, actually gives you information about what other options are in your neighbourhood, so where might you go, for example, for an x-ray, where might you go to have stitches. It was actually interesting: When I looked in my own neighbourhood in London, I was surprised by how many other options there were that I

wasn't aware of. I think all of us might be surprised at what options there are. What we're hoping is that, as people become more aware of this website, they will go there to check what options are available before they go to the emergency department.

Mr. Kevin Daniel Flynn: How much time do I have?

The Chair (Mr. Garfield Dunlop): You've got about six minutes left.

Mr. Kevin Daniel Flynn: Good. That should work then.

I went through a personal experience with a family member who actually ended up on a stretcher for a couple of days in emergency. We were upset about that as a family, obviously, until we realized the stretcher was right in front of the nursing station and he probably had the best spot in the hospital, so we didn't overly complain about that. What appeared to be happening—and this was in a different hospital outside my own community, but I think the same can be said for many of the hospitals in our community—is that people get into the alternate-level-of-care beds and then it's time to move out or move on and there often isn't a place that's available to meet the specific needs of that person. When you look at a hospital as being essentially a building—we look at it as an institution. People come in the one door and they go out the other door, and the idea is that you leave in much better condition than you came in. It's the intent, obviously. People can't get into emergency, can't get into admitting unless we've got a system that allows people to leave at the other end to go on to live the rest of their lives. Often that involves going into long-term care; often it involves hospital in the home.

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We went through a situation in my own community of Oakville where we were going through what I think a lot of hospitals were feeling, and that is that we were having a tough time finding placements for those people who were ready to leave the hospital. My understanding is that, at one point, the metric would have measured that about 24% of the beds on the fourth floor at Oakville Trafalgar Memorial Hospital were occupied by patients who could have been taken care of in the community or in the home. As a result of some of the work that's being done by Oakville—that I understand has become a bit of a best practice around the province, an example of what you can do—they were able to reduce that 24% down to single digits, into I think about 6%, by using "hospital in the home," sending the supports home with the people at the right time—the right care at the right time in the right place, which was not necessarily always on the fourth floor, occupying a hospital bed. As a result of that, other things in the hospital obviously began to change. As you freed up those beds, it was much easier to get into emergency and be seen in proper conditions.

What type of investments, though, are necessary? That's obviously a change in the way you approach things. What sorts of investments are going to be necessary to provide that care in the home that goes home with the people? Is it more expensive than long-term care? Is it more efficient? Obviously, people prefer to be at home rather than in a hospital. I think we all understand that. What change is it going to take in the ministry to allow that to happen throughout the province?

Hon. Deborah Matthews: You've put your finger on one of the real conundrums, I guess, in health care, because what we have still—and we're getting better. But what we still have is a situation where we have too many people who are getting the most expensive care—that is, care in a hospital—but it's actually making them worse, not better, because we know that when people stay in a hospital longer than they need to, their condition actually starts to decline. This is especially true with elderly people. They're not getting what they need, and it's at a greater cost to the system than if they were getting those supports at home.

We've made a very significant investment in our aging at home strategy that's all about providing people with supports at home to prevent them coming into emergency in the first place. And the discharge planning has to start as soon as they arrive at the hospital, right? So we're providing better supports to get them back home as quickly as possible.

One of the successful strategies has been the use of revitalization beds or assess-restore beds, where people who don't need to be in a hospital but still need care can move to a different kind of place where they're up and walking, making sure that they're getting active again before they go home. We're finding that with the right supports, there are a lot of people who can actually be at home, which is where they want to be. This is the job of the LHINs, in concert and in collaboration with all of the other supports in a community.

With this ALC issue, the problem is in the hospitals, but the solution is actually in the community. It's the job of the CCACs and the LHINs, working together with long-term care, everybody working together, to actually provide supports for people. It's about making strategic investments to support programs like Home at Last, Home First, the variety of programs in different parts of the province that really are having outstanding results. We need to continue to strengthen the supports in the community, be it supportive housing or hospice or the range of supports.

The Chair (Mr. Garfield Dunlop): Okay, that pretty well cleans up your time in that round. We'll now go to the official opposition. Mr. Clark?

Mr. Steve Clark: Minister, on page 11 of the Auditor General's report—"Figure 2: Procurement Method and Approval Levels Required by the Directive as of July 2009"—I'd just like to have your comments on whether you think that's a very clear method of approval for contracts. Is it pretty straightforward, in your opinion?

Hon. Deborah Matthews: Could you repeat that? I'm sorry, I was searching for my glasses.

Mr. Steve Clark: It's page 11. It's at the top of page 11. It's "Figure 2: Procurement Method and Approval Levels Required by the Directive as of July 2009."

Hon. Deborah Matthews: And you're asking me?

Mr. Steve Clark: I'm just asking if you think that's a pretty clear directive to follow. To me it looks pretty straightforward, laid out well.

Hon. Deborah Matthews: Yes, I would say this is pretty straightforward. This is the July 2009 directive?

Mr. Steve Clark: Yes. So, I guess when I'm looking, after the July 2009 directive, at page 12 of the Auditor General's report, it does indicate that "the ministry had used a non-competitive, single-source procurement method for about 80% of consulting contracts under $25,000 and 15% of contracts greater than $25,000 in the fiscal year preceding the July 2009 directive." It goes on further on page 12, Minister, to say, "In contrast, from July 2009 to March 31, 2010, ministry records indicate that it did not hire any consultants using single-source procurement."

It appears that, just as you said—it's very well laid out. It's easy to follow. It shouldn't be confusing to anyone, yet when I start looking at the numbers and the two cases specifically that didn't follow the directive, I guess it just, again, gives me cause to ask a few more questions.

I want to go back to the two cases that we talked about earlier this morning. One in particular, the third stage of the contract, the consultant submitted a high bid—$819,000. So it was an open, competitive bid which was less than $1 million. Is that your understanding? Am I reading that correctly?

Hon. Deborah Matthews: It appears that way, yes.

Mr. Steve Clark: Okay. So when we go through the following steps—because a lot of this took place immediately after the directive. It's not like the process started before. When you read the Auditor General's report, we're talking about one month after the July 2009 directive. So we're not looking at a year later; we're not looking at six months later. Immediately after the very clear directive, ministry staff decided to negotiate—and my comment to you is that it looks, given the symbols, just very coincidental that some of these numbers are what they are, because under this directive you and the deputy aren't involved in that process. I just wondered if you had any comment on the coincidence with the numbers and the fact that, in some cases, it's just off of your and your deputy's approval level.

Hon. Deborah Matthews: So is your suggestion, then, that the minister sign off—

Mr. Steve Clark: No, I'm just asking a question. You look at the second one, the pharmaceutical contract. "In May 2009, the ministry awarded a single-sourced contract for $749,000 to a consultant to undertake a review of the pharmaceutical sector." If the increase took place and it was more than $750,000, then you and the deputy would be involved.

Hon. Deborah Matthews: Yes.

Mr. Steve Clark: So I'm looking at some of these figures in this Auditor General's report. It was a month after. I can't understand: When you read the report and talk about the clarity that needed to be done by staff, the discussions you needed to take to make sure that staff follow the July 2009 directive, isn't it troubling that a month after the directive things were already starting to get off the rails?

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Hon. Deborah Matthews: It is absolutely troubling, and that is why the deputy has put in place procedures that would have prevented this from having happened.

Mr. Steve Clark: So what procedures were put in place a month after the directive?

Mr. Saäd Rafi: They took effect after my arrival. When I got there, I changed these authorities. So this is what Management Board of Cabinet requires, effective July 2009. We actually reduced some of these thresholds such that it made them, I would say, more stringent and tighter.

I would agree: I think it is unfortunate that a contract was awarded one or two months after the change in directive. I don't know when the procurement process for these two contracts began. I don't mean that to sound like an excuse, but I just don't know.

Yes, absolutely, if today an individual wants to undertake a single-source contract, one isn't able to. Unless someone's flagrantly trying to break the rules, one isn't able to undertake a consultant contract without these thresholds and even stronger thresholds in place at the ministry.

Nothing is bulletproof, as I think you well know, but the timing of these projects is right on the heels of the change of the directives. I would share your concern in that it is unfortunate, but one of the things that I lent my attention to first and foremost was to address these delegated authorities.

Mr. Steve Clark: But again, you go through the process where you had the original directives—I think it was in November 2007, the first set that this July 2009 set superseded. Is that correct?

Mr. Saäd Rafi: I'm sorry, could you repeat that part?

Mr. Steve Clark: There were some directives—was it November 2007 first?

Mr. Saäd Rafi: There were directives. There have always been directives in place, yes.

Mr. Steve Clark: No, but the ones in July changed significantly the directives that were laid in November 2007.

Mr. Saäd Rafi: They did make changes, yes.

Mr. Steve Clark: I guess I'm trying to figure out, Minister—as I said before, we went down this road with eHealth, and there were the same assurances you gave this morning that it wasn't going to happen again. To me, I just can't understand how, when you have a directive laid out in July 2009, immediately you could have deviations off that directive. It was within a month.

Hon. Deborah Matthews: I'm going to ask Assistant Deputy Minister Ruth Hawkins to come and join the table—if you don't mind, Ruth—just to speak in more detail about the new centralized process that is in place to ensure that proper protocols are followed.

Mr. Steve Clark: I know you've put this process in place. But, Minister, it's a month. It was an immediate deviation from that directive.

Hon. Deborah Matthews: Before I ask Ruth to explain what has been put in place, I think, in fairness, if you look at page 11, there is a section called "Compliance with the Directive." The Auditor General himself says—this is the internal audit; I'm sorry. I'm just going to read this into the record:

"The internal auditors concluded that the ministry had complied with many elements of the directive. Specifically, they noted that in the majority of files reviewed:

"Ministry program areas had appropriately justified the acquisition of consultants, assessed the available resources, and sought prior approvals.

"Signed written contracts were in place with acquired consultants, with the exception of two instances of single-source procurement of services totalling approximately $573,000.

"The appropriate procurement method had been used for the type and value of the procurement.

"Proper approval had been obtained for subsequent amendments to extend the contract and increase its value."

So, yes, there are two cases that the Auditor General refers to, but I think it's important to note that we really have come a long way.

I'm going to now ask Ruth to explain the process in place to ensure proper procurement.

Mr. Steve Clark: Just before you do that, can you read into the record—I know you said "two instances of single-source procurement of services totalling approximately $573,000." Can you do a split of what those two contracts were?

Hon. Deborah Matthews: I don't have that information immediately. We'll search to see if it's here.

Mr. Saäd Rafi: Mr. Clark, excuse me. I didn't get the reference—

Mr. Steve Clark: The minister read into the record, from page 11, "Signed written contracts were in place with acquired consultants, with the exception of two instances of single-source procurement of services totalling approximately $573,000." I just ask that you read into the record what each—

Hon. Deborah Matthews: We can't read it into the record if it's not here.

Mr. Saäd Rafi: I don't have it at my fingertips.

Mr. Steve Clark: Can you get the information?

Mr. Saäd Rafi: We'll try. I'll have to consult with the auditor as to what he looked at and our own internal audit people, but I'm pretty sure we can, yes.

Mr. Steve Clark: Because just to let you know, to go back above that page, in the non-competitive July 2009 procurement, any non-competitive contract less than half a million dollars needs the deputy's and the minister's approval.

Hon. Deborah Matthews: So your question is, did either one of them meet the $500,000 threshold?

Mr. Steve Clark: Well—

Mr. Saäd Rafi: I think this—pardon.

Hon. Deborah Matthews: Go ahead.

Mr. Saäd Rafi: I will verify this, but I think this internal audit report reflects the activities against the 2007 directive. It's just a point of clarification. I'll endeavour to get that information for you—

Mr. Steve Clark: But you can see my point. If it's clear that you've got two that total just over half a million dollars, I just want to find out whether one of them was under $500,000, because based on this July 2009 directive, the offices of minister and deputy minister were the levels of approval.

Hon. Deborah Matthews: We'll get you the information if we can but just want to note that the November 2007 directive was in place at the time of these contracts. We'll check and get that clarity if we can.

Maybe, assistant deputy, if you could just speak to the—

Ms. Ruth Hawkins: I'm Ruth Hawkins; I'm the chief administrative officer with the Ministry of Health and Long-Term Care. Just further to what the minister and deputy minister referred to, we have certainly put in place very strengthened ministry delegations of authority. We have centralized the management and communication of those delegations as well.

Further, we have taken a step that we're hoping will be very beneficial, and that is that starting in April of this year we centralized all of our procurement activities and we're calling it the end-to-end procurement process, whereby there is a group of individuals who will be assisting the staff within the ministry in terms of the procurement activities that will be taking place. That same group, in addition, is also responsible for the training. That is a training activity that will continue, as it is not something that you do once over and hope that you never have to do it again. It is something that we will be doing and continue to do on a continuous basis.

Thirdly, we have also put in place strong transfer payment protocols. Those particular protocols are also put in place, and we have extensive training as it relates to those protocols.

Lastly, we have also centralized our processing such that we are segregating both the spending and payment authority. That is also a further check in terms of any payment activities that take place.

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

Mr. Steve Clark: Again, Minister, I'm having real difficulty with talking about what happened with the two contracts as opposed to what's moving forward. It's troubling that we can't seem to get to the crux of the matter. I just can't believe that you can't provide the committee with a little more information on what happened from July 2009 to a month later, when clearly, this was off the rails.

The Chair (Mr. Garfield Dunlop): There are four minutes left in this round, by the way.

Hon. Deborah Matthews: I have to say I'm having a bit of difficulty as well understanding—well, actually, I have no difficulty at all in understanding where you're coming from. But if you read the report as a whole, and I think we owe it to the Auditor General to read the report

as a whole, the Auditor General has said that, generally speaking, the ministry has been in compliance, but he does highlight some areas where we need to improve, and where I think you have heard that we have improved.

No one here is suggesting that there wasn't room for improvement; there was room for improvement, and that's why we have put in place those improvements. Now, I suspect that in future years the Minister of Health will be sitting here at estimates and there will be further improvement required. That's part of the nature of a large organization like the government of Ontario, like the Ministry of Health and Long-Term Care: We will always be looking for ways to improve.

What the Auditor General has laid out and, I'll repeat, what he has said is that his review of a sample consultant services engagements from April 2009 to February 2010, keeping in mind that July 2009 was when the directive came down, confirmed that the ministry was, for the most part, complying with the requirements. Let me repeat: The Auditor General says that the ministry was, for the most part, complying with the requirements.

I don't know what information you have that the Auditor General didn't have to come to the conclusion that you appear to have come to. What I can tell you is, the Auditor General pointed out places that we need to improve. We take that responsibility very seriously. We have put in place—and actually put in place processes prior to the Auditor General's report to strengthen our procurement system. We have introduced legislation, which I understand you are not supporting, that will broaden accountability to the broader public sector. That's movement in the right direction. We are getting better, we are getting stronger, and we will continue to improve as long as we're in government. I can assure you of that.

I don't quite understand what information you don't have that you need to have. If you can give me the questions you are looking for answers to, we will do our best to find those answers. But overall, the Auditor General, an officer of the Legislature, has said that for the most part, the ministry was complying with the requirements. I take some comfort in that. Having said that, the Auditor General does point out areas where we need to do better, and we have put in place those protocols. As you have heard from Ruth Hawkins and from the deputy, we have put in place, I would say, a process that far exceeds the recommendation of the Auditor General.

The Chair (Mr. Garfield Dunlop): That will conclude our time this morning. Thank you very much to everyone in the committee. Minister, thank you and the staff. We'll recess until 3:45 this afternoon.

The committee recessed from 1024 to 1545.

The Chair (Mr. Garfield Dunlop): We have a quorum here, it's 3:45 and we did want to try to finish up this afternoon. Because we would have about another 12 minutes left over at the end of the session and we didn't want you to have to come back here for 12 minutes, your government members have agreed to give up about six minutes in each round.

Because the NDP is not here, we'll go back to them after. But we'll start with Ms. Sandals. If you can carry it forward, we'll take the first 14 minutes, then.

Mrs. Liz Sandals: Okay, great. I wanted to talk a bit about nurses, if I may, Minister, because we often talk about doctors, but in fact, it's often the nurses that are providing the care. In so many settings, it's the nurses that are really, really crucial. It doesn't really matter whether it's a hospital or long-term care or home care, all sorts of forms of community care are now with nurse practitioners taking a larger role. It's often in the emergency room or nurse-practitioner-led clinics—they play the lead role there, but they have a really valuable role in family health teams.

I know that after the previous government, where they seemed to manage to lose 6,000 nurses, one of our key promises has really been to nurture the role of nurses and to make sure that there are more nurses in the health care system. I wonder if you could explain a bit about how that initiative to get more nurses in the system has been going.

Hon. Deborah Matthews: Thanks very much for the question, and it is a very important one. We often say that nurses are the backbone of our health care system, and I really do believe that while everybody has a very important role to play, we really do lean on our nurses to provide that essential care.

You're quite right: When we came to government, there had been some serious problems with nurses being laid off, and we didn't have enough nurses. Of the nurses that we did have, too many were working part-time, often in several different hospitals. I think that really came to light during SARS, when we actually, at a system level, started to see the impact of having nurses working shifts in different hospitals.

We actually have created over 10,700 nursing spots in Ontario since 2003, and 1,200 in the last year alone. So even though we're facing some very difficult financial constraints, we're still hiring more nurses.

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There's been some confusion over whether or not there have been nursing positions lost. The reality is that what we're counting is actual net new nursing positions. Sometimes, if there's a reorganization, layoff notices are given—it's a contractual obligation—but those do not, most often, result in a nurse actually losing a job. There are hundreds of job vacancies for nurses right now. Nurses are in high demand.

You might be interested to know where those 10,700 nurses are: 5,000 of them are in hospitals—5,000 more nurses; 3,100 more nurses in long-term-care homes—3,100 more in long-term care; 900 in community settings; 1,600 in family health care; and 200 more nurses in public health. There are a lot more nurses working.

One of the important innovations in Ontario: We're one of the very few jurisdictions in the whole world to guarantee new nursing graduates a full-time job. It's our nursing graduate guarantee fund. That has actually impacted 9,000 new nursing graduates since we took over.

Another area that is really encouraging is the practice of nurse practitioners. We've doubled the number of nurse practitioners practising in Ontario. As you say, they are working in many different settings. They are working in hospitals and in family practice. They are now operating nurse-practitioner-led clinics. The first one in Sudbury has registered close to 2,000 people in the first year of operation who did not before have access to family care—nearly 2,000. I recently opened one in Thunder Bay. As soon as word got out that there was a new primary health care team in place, the phones started ringing. They will have no trouble filling their complement of patients. We've got 11 new clinics in the process of opening. We're committed to opening 25, and we've announced those 25 locations. We're excited about the opportunities for nurse practitioners.

Another area that we really turned our attention to was the percentage of nurses working full-time. We're shooting for 70%. That's what nurses tell us they think the number should be. We've gone from just under 50% to 64%. We're making good process in getting more nurses full-time work, and that's the work they want.

We're also working to retain nurses. We've invested $40 million in the nursing retention fund. We've got a late career initiative. At every stage of a nurse's career, we've got something going on to keep them working.

You might remember it wasn't very long ago when nurses were heading south of the border. They'd get their training here. We know the best nurses in the world are Ontario nurses. That was a secret that we weren't able to keep to ourselves, so other jurisdictions actively recruited nursing graduates from Ontario.

Now what we're doing is really putting supports in place. We treasure those nurses. We want them to stay in Ontario. We want them to work as many years as they can. That's why the late career initiative has been wonderful: because 12,000 nurses have been able to benefit from that. What that is—part of their time is spent actually doing research and bringing best practices into their organizations, and part of the time is still spent doing front-line nursing, but the nurses whom I've spoken to who've participated in the late career initiative find it enormously rewarding.

The other thing we're doing: When we came into office, we had a serious problem with nurses being injured on the job—back injuries and so on. That was part of the reason why they weren't practising as long as we'd like them to practise. One of the things we did is we funded new bed lifts in hospitals and in long-term-care homes—19,000 bed lifts—to reduce the wear and tear, that physical challenge of nurses.

I think we've done a good job with nurses, but we still have more to do.

Mrs. Liz Sandals: Thank you. I'm so glad you mentioned the collective agreement aspect of it. As you know, I come from the school board sector. School board collective agreements—when teachers are surplus to a school, the student population in a school is going down, they're declared surplus to the school. It's right in the collective agreement, how you move them from one school to another school. People might well get moved, in a big board, a geographically large board, to a school that's an hour away, but there's no issue around layoffs. So I was quite dumbfounded the first time my local hospital CEO came and said, "We're doing some reorganization at the hospital. This is going to be smaller and these two sections are going to be bigger, and everybody will get transferred," and the next thing I discovered in the newspaper was, "Layoffs at Local Hospital." When I checked it out, it was this business of, "According to the collective agreement, they have to be laid off," but of course they all got hired back five minutes after they'd been laid off, and they just moved to a different floor.

I think that's really very confusing for the public, to wrap their head around the fact that you get laid off because you're getting transferred from one floor to another floor. I'm glad that you explained that.

Where are we at on time, Garfield? Chair? Where are we at on time?

The Chair (Mr. Garfield Dunlop): You've got another five minutes.

Mrs. Liz Sandals: Let's leave that, and we'll put it on the next round, given that we're giving some time up, okay?

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

Mrs. Liz Sandals: So put that on the next round.

The Chair (Mr. Garfield Dunlop): Okay, that's good. I'll keep an eye on that for you.

We now go to Mr. Hampton of the third party. We jumped ahead of you when you weren't here. Go ahead. You have 20 minutes.

Mr. Howard Hampton: I understand Mr. Prue asked some questions earlier in the day, so I want to ask some questions as follow-ons to those. What steps is the government taking to ensure that care levels at each home are increased at least proportionately to average increases in resident care need? The data from 2004 to 2007 shows that care hours did not increase as much as care needs increased.

Hon. Deborah Matthews: Let me carry on from this morning, then. We now have a way of quantifying the need of residents in long-term-care homes. It's called a MAPLe score. It's a measure that determines, "How much care does this person need? What are their abilities and where are they going to need some help, getting on?" We now measure the acuity of the residents and we do fund each home in accordance with the combined acuity of the people who live in those long-term-care homes.

We are very much focused on improving the quality of care in our long-term-care homes. When we talk about quality of care in long-term-care homes, we're really talking about metrics that would matter to the residents and to the family members of those residents: How are they doing? Are they eating well? Are they involved in activities? What's their mobility? Are they able to feed themselves and so on?

We actually are now starting—this is established now. We don't have all the homes engaged in this, but we are

on our way to that. It's an initiative called Residents First. We measure outcomes for people in our long-term-care homes. We believe, and the community believes, that what really matters is the outcome: How are people doing? Are they getting pressure ulcers? Are they getting the activities and the care they need?

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It's those outcomes that matter. As I said this morning, we know that the better the job we do in keeping people home as long as possible, what that means is that the acuity levels will increase in long-term-care homes. So those who need the care in long-term care the most will get that care in a long-term-care home, but others will be able to be cared for at home.

It's something we're watching very carefully. As I say, the metrics that we're really focusing on are how the residents are doing on measures that matter to them.

Mr. Howard Hampton: Again, the data from 2004 to 2007 show that while the measurement of care need went up like this, the measurement of care hours did not go up proportionately.

Hon. Deborah Matthews: I'm not familiar with the document you're quoting there. Mr. Prue told me he would get that to me. I have not yet seen that. It would be helpful if I knew where that was coming from.

Mr. Howard Hampton: Are you making the case, then, that care hours have gone up proportionate to care need?

Hon. Deborah Matthews: What I'm saying is that we are very focused—and I think the deputy actually has some more detailed numbers here. What I'm saying is that outcomes are what we are tracking; the outcomes for patients are of utmost importance to me. So maybe if the deputy has some of the numbers, I'll hand the microphone over to him.

Mr. Saäd Rafi: I guess I would say that the amount of time or care hours per resident across all professional categories has increased year over year. As I mentioned to Mr. Prue, the information provided on the 2008 data compares that, as requested, against the various types of homes, whether they be for-profit, charitable, not-for-profit and municipal.

With respect to care need, again, I'm not sure how that is defined or how it's being applied. If we have a comparator, we will try to get you that comparator for 2008 information. We can certainly do that.

In terms of direct care, we did provide a fairly detailed analysis from 2004 through to 2007 in six-month increments on direct care by type of home, direct care by type of worker, so a registered nurse, an RPN—registered practical nurse—or a personal support worker, and then also provided funding across the sector by type of home.

If you combine funding with types of hours and the increase in staff, both in nursing and RPNs, as well as personal support workers, one would see from 2004 to 2008—I used the number and added a year—that has been an increased trajectory in each of those years. So more money for the workers themselves and an increase in the amount of time per resident.

Mr. Howard Hampton: Again I'll ask the question: Are you saying that the increase in care hours has been proportionate to the increase in care need?

Mr. Saäd Rafi: I personally can't answer that question for you until and unless I know how "care need" has been defined and what that metric is. I'm sorry; I'm not equipped to say yes or no to that today.

Mr. Howard Hampton: Okay. Is the ministry aware that for-profit nursing homes, which fall within clause 2(1)(k) and subsection 2(2) of the Public Sector Salary Disclosure Act, have not been filing annual reports?

Hon. Deborah Matthews: No, I'm not aware of that, and I know that it is something we'll look into. Thank you for bringing that to our attention.

Mr. Howard Hampton: Can you tell me why they haven't been filing reports?

Hon. Deborah Matthews: Let me find out.

Mr. Saäd Rafi: Mr. Hampton, are you suggesting that the for-profit are required and they are not? Staff are telling me that it's their understanding that the for-profits are, under the act, not required to report.

Mr. Howard Hampton: Our understanding is that for-profit nursing homes, which fall within clause 2(1)(k) and subsection 2(2) of the Public Sector Salary Disclosure Act, are required.

Mr. Saäd Rafi: Could we have the opportunity to check with finance, who manages public sector salary disclosure, as to whether that is—if you don't mind me saying this—a correct interpretation, and if it is, perhaps trying to get the answer as to why not?

Mr. Howard Hampton: Just assuming we're right on this, what is the remedy for those contraventions?

Mr. Saäd Rafi: Again, this is a Ministry of Finance responsibility. I'm not schooled in the Public Sector Salary Disclosure Act or its subsection, so I'd have to look into that and formulate a response for you.

Mr. Howard Hampton: Okay.

Again on long-term care, when will the Sharkey long-term care implementation committee report be released publicly?

Mr. Saäd Rafi: I don't know whether there was an indication of a public release of the report. Again, I'd have to go back to when the announcement was made—or the appointment, I should say, of Ms. Sharkey, on that report—to determine whether there is an intention to have a public release. So again, I need to get back to you.

Hon. Deborah Matthews: What I would like to say, though, is that our commitment to long-term care—our record speaks for itself. We've increased funding by over $1 billion. We've increased funding by 68% when it comes to long-term care. In this past year alone, it's an increase of 7%, which, as you know, in a difficult economy is a true commitment to long-term care. We've got over 6,000 new full-time staff working. That includes 2,300 nurses. We're delivering 12 million more hours of hands-on care in our long-term-care homes.

As I say, what really does matter is that people who live in long-term-care homes are getting the care that they need and that their family members expect they will

get. That means measuring outcomes. We're measuring things that never have been measured before, and through the Ontario Health Quality Council we're publicly reporting on those outcomes.

I think that's the way of the future when it comes to long-term care. I think people deserve to have comfort when their loved ones are in a long-term-care home so that we can all sleep at night knowing that our loved ones are cared for.

I do want to really credit the work of Monique Smith when she was the parliamentary assistant to the Minister of Health. She embarked on a very thorough review of long-term-care practices. She issued a report, and that has really been our guide as we have improved the quality of care—not just the quality of care, but the access to care—in our long-term-care homes. So I do think that the work of that particular parliamentary assistant really does deserve congratulations. It has really changed the kind of care people get in long-term-care homes in the province of Ontario.

We're continuing with our work. We've opened 8,300 new beds. I was happy to be at the opening of a long-term-care home in London just a couple of weeks ago. The other thing that we're doing is, we are rebuilding the beds that exist. We still have too many homes that do not meet today's standards, and we are moving forward to redevelop 35,000 beds. I'm sure that you have been in some of those homes where the standards aren't what we would consider acceptable today, so we're moving forward to redevelop 35,000 beds in addition to adding capacity.

I think that the deputy has—

Mr. Howard Hampton: Former Minister Smitherman committed that the Ministry of Health and Long-Term Care would report staffing information by long-term-care home on the Ministry of Health and Long-Term Care public website. I can give you the media reports on when he committed to that. Can you tell us when that is going to begin to happen?

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Hon. Deborah Matthews: I don't have any information on that issue—

Mr. Saäd Rafi: Yeah, I'm sorry. We have provided, I think, that level of detailed information. I'll find out whether there's a plan and a date on which to post that information. I don't know.

Mr. Howard Hampton: I want to be very clear: The commitment was to report staffing information by long-term-care home on the Ministry of Health and Long-Term Care website.

Hon. Deborah Matthews: I'll undertake to take a look at that.

Mr. Howard Hampton: Competitive bidding: Is the moratorium on competitive bidding still in place?

Hon. Deborah Matthews: Yes, it is. I think it's fair to say that, as we turn our attention to improving quality of care in long-term-care homes and quality of care throughout the health care system, we need to make sure that whatever we do is aligned with our goal of improving quality of care. So yes, that moratorium—

Mr. Howard Hampton: I want to be very clear: Talking about the home care sector, the moratorium on competitive bidding is still in place?

Hon. Deborah Matthews: Yes, it is.

Mr. Howard Hampton: So there have been no new contracts?

Hon. Deborah Matthews: Before I definitively say no, there may have been a situation where one organization got out of the business that I'm not aware of—

Mr. Saäd Rafi: Again, if I could ask a definitional question. Would "new contract," in your parlance, include a renewal?

Mr. Howard Hampton: I would assume "moratorium" means you're not going to go down that road any further.

Mr. Saäd Rafi: Sorry; I'm just not sure how to answer if I'm not sure what "new contract" means. If a contract comes to expiration and it's renewed—I think just to pick up on the minister's point, it may be the case that that contract was renewed and carried on.

I think what the ministry has been trying to work with the CCAC association and CCACs individually on is to ensure that the quality and calibre of service received by home care recipients and residents throughout Ontario is of an equal calibre. I think that what we could say fairly to all service providers is that that is not the case today. Some time is being spent, and that's why the suggestion and request of CCACs not to procure or put out RFPs for new services has been kept in place.

I'm not sure, and I just don't have enough information at my fingertips to know, whether a renewal was undertaken. That's why I'm sort of probing you a bit on that.

Mr. Howard Hampton: Let me be very specific, then. Could we have a list of any contracts that have been granted since the moratorium was put in place?

Hon. Deborah Matthews: We'll take a look at that. But I do want to be clear that there are contracts that would have expired. We deal with those renewals as they come up. To the best of my knowledge, and I stand to be corrected, none of those have gone through an RFP process, but I will confirm that, that we have renewed existing contracts.

We think it's very important that we get this right. We are, as I've said, very focused on improving quality. We need to work with providers to ensure that people are getting high-quality care throughout the province. We're not going to move forward on a fair bidding process until we know that we have it right, especially in light of our commitment to quality.

Mr. Howard Hampton: Let me be even more specific, then. Could we get a list of any contracts that have been granted whether or not they are a renewal? Could we get a list of any contracts that have been granted?

Hon. Deborah Matthews: I think we understand what you're looking for, and we'll do our best to get that for you.

Mr. Howard Hampton: And could we get the dollar amount of each contract?

Hon. Deborah Matthews: Again, I will look into that request.

Mr. Howard Hampton: And whether the contract is with a for-profit or not-for-profit agency?

Hon. Deborah Matthews: Again, we will look into it. I'm not sure that we keep that information, but I'm sure there are people who could look down the list pretty quickly and see what category they might fall into.

The Chair (Mr. Garfield Dunlop): Two minutes left.

Mr. Howard Hampton: What are the current maximum amounts of care that can be approved for home care and how does the cost for those maximums compare to the cost of care in a long-term-care home? In other words, as I understand it, you do have some maximums specified for home care costs.

Hon. Deborah Matthews: There was a maximum of 60 hours per month. We have increased that to 90 hours per month. I believe there is no cap for people who are just coming out of hospital.

It looks like we're actually going to get something a little more detailed here.

Mr. Saäd Rafi: Just to verify—

Hon. Deborah Matthews: Just to verify; excellent. We're working hard to provide people the care they need in their home if at all possible. One way to do that is to increase those caps.

Mr. Howard Hampton: I want to be clear—

Interjections.

Mr. Saäd Rafi: Sorry.

Mr. Howard Hampton: Do you set a monetary amount? In other words, when we're talking about maximums of care, you can measure that in hours, but you can also measure it in dollars. Do you set a dollar amount which captures maximum care?

The Chair (Mr. Garfield Dunlop): Try to answer this fairly quickly, deputy, if you could.

Mr. Saäd Rafi: I don't believe we set a per diem for home care but I will verify that—or per hour for home care. Certainly we do have a per diem for long-term care and—

Mr. Howard Hampton: What I'm after here is the comparison in cost.

Mr. Saäd Rafi: I would suggest that 24/7, 365 care as a resident in a long-term-care facility is going to be more expensive than 90 hours per month.

Mr. Howard Hampton: But if you look at the maximums that are afforded through home care you should be able to come up with some relative measurements. Here's the cost of home care, maximum; here's the cost in a long-term-care home.

The Chair (Mr. Garfield Dunlop): Okay, we'll get back to that in the next round.

Thank you very much to the third party. Now we'll go to Mrs. Elliott. We'll be joining you again just in a minute here, Mr. Hampton.

You've got 20 minutes.

Mrs. Christine Elliott: Good afternoon, Minister, deputy minister. I do have a series of questions on a variety of topics, so as I move from one to another I hope you'll bear with me.

I'd like to start with the 10-year health care plan if I could, please. We had an FOI asking for a copy of the 10-year health plan in June 2009 and it was indicated the plan couldn't be released because it was a cabinet document, but they did confirm that a 72-page document did exist. When we asked you about it last year, I believe you were relatively new in the portfolio and you indicated that you wanted to have time to study it. Can you advise us of where the plan sits right now and when you expect it to be released?

Hon. Deborah Matthews: We are actually, as you've heard over and over again, really focused on improving the quality of care in this province. We are doing that in several different ways in different sectors of the health care system. We're also absolutely committed to improving the integration of our health care system and that, of course, is a very big job that our local health integration networks are tasked with.

Another area that we're focusing on is getting back better value for the money we spend on health care, hence our reforms to generic drugs, which will save us significant amounts of money in health care that we can then invest in other areas that actually improve the health care of the people of Ontario. We're focusing on chronic diseases, including diabetes. We're also focused on improving access to primary health care and getting wait times down for various surgical procedures, diagnostic tests and now emergency departments. So there are significant strategic initiatives in the ministry.

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You've heard me talk about the importance of making sure people get the right care they need as close to home as possible. What that means is investing more in the community so that we can actually support people in their homes for as long as possible. There are several initiatives that are under way right now.

Each of the LHINs has developed its own strategic plan, and those are available—the South West LHIN and the Toronto Central LHIN, for example. You can go and see what their more localized strategic plans are.

We've passed legislation, the Excellent Care for All Act, which squarely puts the responsibility on people in the health care system of improving the quality of care. It also focuses on relying much more heavily on evidence when we're making our funding decisions. We are currently funding too many things for which there is not evidence to support those expenditures. We're moving forward on the elements of the Excellent Care for All plan.

Mrs. Christine Elliott: But, Minister, with respect to the status of the overall plan, is it complete yet?

Hon. Deborah Matthews: If you're asking whether we have one single document that outlines all of these initiatives, the answer is no. But I think we've been very, very clear about where we are going in our strategy to get

best value and best care for the people of Ontario. As I say, each of the LHINs has developed a strategic plan that reflects the needs in their particular part of the province.

Mrs. Christine Elliott: Former Health Minister Smitherman promised that there would be a plan released in the spring of 2007. Here we are some three years later and still no plan. Do you intend to have an overall health care plan for the province of Ontario?

Hon. Deborah Matthews: I would say that we have a very clear strategic plan that has been articulated very, very clearly. It's encapsulated, really, in the Excellent Care for All Act. It's about improving quality, it's about improving access, and it's about getting best value for health care dollars.

We, as a government, are committed to spending more every year on health care. I know it is the position of your party to actually cut spending on health care. That is not our position. Our position is to keep on spending, keep on improving access, keep on improving quality and, I must say, keep on building the infrastructure that really is the foundation of much of the health care that is delivered in this province.

Mrs. Christine Elliott: The Excellent Care for All Act really only speaks to hospitals at the present time—

Hon. Deborah Matthews: No, that is not correct.

Mrs. Christine Elliott: What happened to the 72-page document? Can we have a copy of that if that's the document that you're working from? What are you working from in order to come up with what appears to be bits and pieces and not really a—

Hon. Deborah Matthews: This is not bits and pieces. This is a fundamental shift in the culture of health care in this province. The work on Excellent Care for All is being extremely well received in the community. Excellent Care for All does apply to all health care organizations. We are starting with hospitals—actually, we began with long-term-care homes. We are now moving to hospitals, where every hospital will have a quality improvement committee. They will report directly to the board. They will compare their quality indicators to other hospitals across the province. Those quality indicators include the patients' experience in the health care system, so it's putting patients first. Each of the hospitals will be required to compare how they're doing to other hospitals and develop an annual plan to improve the quality in those organizations.

This is very difficult work for hospitals, and we acknowledge that hospital boards are going to have more responsibility in their communities. But I think they're embracing the change and improving the quality, improving value, improving access. That's what we're doing.

Mrs. Christine Elliott: So you're really telling us that there is no overall document that encapsulates an overall health care strategy for the province of Ontario, and there is no intention that there will be one, notwithstanding the promise that was made by the previous health minister?

Hon. Deborah Matthews: There's been work done on developing that document. I'll be honest with you: I'm more interested in getting the results than putting out a fancy-looking document. We've been very clear. We publicly post wait times, publicly post infection rates. We now have a new website where people can easily access the health care options in their communities. We're moving forward on improving the quality of care in this province, improving the access to care in this province, and for me, getting those results is more important than issuing a document.

Mrs. Christine Elliott: Do you expect that there will be a document issued before October 2011—

Hon. Deborah Matthews: What I can tell you is that there is work going on. My highest priority is actually getting the job done.

Mrs. Christine Elliott: I guess my last question would be, if there is no overall plan, how do you expect the LHINs to be able to plan for their own particular region when they don't know what the bigger picture is?

Hon. Deborah Matthews: Oh, the LHINs absolutely know what the bigger picture is. We are very, very clear with the LHINs about what their responsibilities are, and we work hard to ensure that they know what our priorities are.

Right now, the first job of the LHINs is to tackle, with their partners, issues around ALC—alternate level of care—and emergency department wait times. Of course, the LHINs' responsibility is to integrate care in the community so that a person navigating the system can do so in a way that is seamless to the individual. We're not there yet, but that's where we're going. I can tell you that tackling the problem of ALC is forcing that kind of integration, and we're seeing tremendous results. I met a gentleman the other day who, because of the work of the LHIN and the CCAC and other community partners, has actually moved from long-term care back into his own apartment, with significant supports around him that allow him to stay at home in his community. That's the kind of success that our LHINs are capable of achieving. We're starting to see that work pay results. We are an aging population. We are growing older, and we are growing older with more complex health conditions that require more intensive care as we age. We have to be prepared for the aging of our population, so getting this right, now, is essential to the protection of a universal single-payer health care system.

Mrs. Christine Elliott: Is there a document that contains these directives to the LHINs, and if so, could we obtain a copy of it?

Mr. Saäd Rafi: There are several documents, I would say. It starts with LHIN legislation that gives them guidance on their role and mandate and set of responsibilities. From there they engage in accountability agreements. For example, they would have accountability agreements with hospitals and other health care partners within their region. In addition to that, they work collaboratively, not just vertically within their own geography but collaboratively across the province,

guided by such things as, starting in April, quality plans for hospitals and the quality outcomes, which we discussed here earlier, in the community care sector: long-term care and home care. There is, I would say, an amalgam of both documents and strategic intent that they're guided by, as well as a day-to-day interaction through integrating services across the sector.

Mrs. Christine Elliott: But is there anything specifically that has come from the ministry directing the LHINs to be focused on the two items that the minister mentioned?

Mr. Saäd Rafi: I'd have to scrutinize the legislation in detail to say if those specific items find themselves in the legislation. I must confess I haven't looked at a detailed accountability agreement with a hospital because they're under renewal right now. We'd have to get back to you as to what is in the legislation that would guide the LHINs. But I would hope that some of that is certainly there.

Hon. Deborah Matthews: We also have annual accountability agreements with the LHINs, where we lay out very clearly what we're expecting them to accomplish.

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Mrs. Christine Elliott: All right. If—

Mr. Saäd Rafi: Sorry; pardon me.

Mrs. Christine Elliott: Go ahead.

Mr. Saäd Rafi: I was going to say yes, of course. I neglected what is a fairly structured and detailed process, so there are 14 MOUs with the LHINs and the ministry, and they cover everything from, in no particular order, effective controllership to the delivery of quality in their LHIN through their partners: hospitals, long-term-care homes, and soon community care access centres.

Mrs. Christine Elliott: Just so I understand, did all 14 MOUs, then, contain this directive from the ministry that "You are to be focused on these particular areas"?

Hon. Deborah Matthews: That is correct, yes.

Mrs. Christine Elliott: Okay. Thank you.

Next, I have some questions again with respect to nurses. I know that some questions have already been asked, and I do have some particular questions that I don't necessarily expect you have the answers to at the tips of your fingers, but if you could undertake to provide me with the information in 30 days or as soon as possible thereafter, I'd be grateful.

The first question has to do with the new nursing graduates finding full-time employment in Ontario under the nursing graduate guarantee program. I'm wondering if you could provide me with a breakdown of how many new nursing graduates were participating in 2010-11 and for the three years prior to that, so it would be 2009-10, 2008-09, and 2007-08. I believe you mentioned 9,000 graduates overall, but if we could have the breakdown over that four-year period.

Hon. Deborah Matthews: By year?

Mrs. Christine Elliott: Yes.

Hon. Deborah Matthews: We can probably get that for you, maybe even quickly. What I can tell you is that nursing graduates get full-time jobs. This has been a very successful program because it gives them the opportunity to work full-time, most often in hospitals, where they get that hands-on experience that is extremely valuable to them.

Mrs. Christine Elliott:. Okay. Again, just to—

Mr. Saäd Rafi: Sorry, may I ask for one clarification? Mrs. Elliott, were you looking for what the specific program nursing graduate guarantee has supported, or the number of nurses in 2008-09, 2009-10 and 2010-11?

Mrs. Christine Elliott: The number of nursing graduates involved with the program in those years.

Mr. Saäd Rafi: We will have to get back to you on that.

Mrs. Christine Elliott: All right. Thank you. And in addition, I wonder if that could be further broken down by the number of graduates who found permanent full-time jobs and those who found temporary full-time jobs, if you have that information.

Hon. Deborah Matthews: Well, the nature of the program is that it is a temporary position. If my memory serves me correctly, it's a nine-month—

Interjection: It can be seven—in that range.

Hon. Deborah Matthews: So it is a graduate guarantee for a fixed period of time, and then the nurses do go through the application for full-time work, or part-time work, if that's what they prefer.

Mrs. Christine Elliott: I guess that would be my question. How many people have been able to find full-time work following the program, permanent full-time?

Hon. Deborah Matthews: I'm not sure we collect that information; we'll have to check to see. We may have something here.

Mr. Saäd Rafi: I can give you one data point for 2008-09 of participants in the nursing graduate guarantee program: 76% of those new graduates transitioned into full-time employment. That was our experience in 2008-09, as compared to only 40%, and only 14% of registered practical nurses, who were obtaining full-time employment after graduating. Sorry; that's a 2005 comparison to what was then in place in 2008-09.

Mrs. Christine Elliott: Thank you. If I could get the information for the rest of the years, I would be grateful.

Mr. Saäd Rafi: Yes, we'll try to do that.

Mrs. Christine Elliott: All right. Thank you.

The next question is on new nurse-practitioner-led clinics. Can you tell me how many are open, or will be open by the end of 2010, and how many more will be open by October 2011?

Hon. Deborah Matthews: Yes. I'll start with the last question first. Our hope is that all 26 will be open—that's Sudbury plus the 25 new ones—by the end of 2011. We're hoping that the first wave of 11 new clinics will be open this calendar year. Belle River, Belleville and Thunder Bay are all open. Maybe there are more. Those three for sure are open. I attended the opening of the one in Thunder Bay just a week or two ago.

They are all on track to open. As you can imagine, this is new, this is groundbreaking work, and we're asking those nurse practitioners to do work that they haven't

done before: the development agreements, capital grant agreements, finding space, finding staff, the operating agreement that we have with them.

There's work that has to be done, but what I can tell you is that there is real enthusiasm for this model of primary care, and I have every confidence that they'll be a big success.

Mrs. Christine Elliott: So that would leave another 15 clinics, then, to be opened within the next 11 months or so. Is that correct?

Hon. Deborah Matthews: No. So 26 in total—

Mrs. Christine Elliott: Yes.

Hon. Deborah Matthews: Sudbury is the mother of nurse practitioners, and it's been open for some time, and then we've announced 25. The first wave was 11 NP-led clinics that we announced several months ago. Of those, three, I believe, are up and running and the others are in various stages of development and are anticipated to be open by the end of—

Interjection.

Hon. Deborah Matthews: Okay. We have Joshua Tepper. You can come and go through this, if you don't mind.

The Chair (Mr. Garfield Dunlop): And you've got a minute and 30 seconds to do it.

Dr. Joshua Tepper: Yes, no problem. And I may, by the end of that, have your dates as well for the NGG, the numbers of participants for each year. We won't be able to do this year because the graduates are staggered over time, and they have up to six months after graduation in case they want to rest before they start their job. So we won't have this year for the new graduate guarantees.

But you're interested in the start dates for the NP-led clinics?

Mrs. Christine Elliott: Yes, please.

Dr. Joshua Tepper: Okay. Algoma-Sault Ste. Marie, April 2011; Lakehead-Thunder Bay, November 2010; VON Belle River township, August 2010; Anishnawbe-Thunder Bay—we're still in discussions with them, but we should have a potential time; they're looking for appropriate clinic space for that community. Belleville, August 2010—I believe the minister attended the opening; the Canadian Mental Health Association Oshawa, December 2010; French River-Alban, May 2011; Georgian-Barrie—temporary location, January 2011, with a permanent location in fall 2011; Glengarry South, February 2011; Huronia-Oro Station, May 2011.

The Chair (Mr. Garfield Dunlop): That's a good one, that Oro Station one.

Interjection.

Dr. Joshua Tepper: Capreol, August 2011; North Channel nurse-practitioner-led clinic, formally known as Central Algoma, September 2011; Emery-Keelesdale, formerly North York-West Toronto, June 2011; Georgina-Sutton, February 14, 2011; and Health Zone London, February 2011. And the last two—

Mr. Saäd Rafi: While you're turning the page, can I just interject and say "projected"—because of the vagaries of getting operational. We sound quite certain by saying by June 2011 etc., and the last two are June and November 2011, but I think our experience has been that every clinic has its own sort of approach and will take a varying degree of time. But we hope to have these projected dates in place.

Dr. Joshua Tepper: We update this every week, and we are in local communication. There's a total of 15 steps, with the 15th step being a ribbon-cutting. So with each of the 14 steps preceding that final stage, there's a very clear process that we're working to streamline and improve.

Hon. Deborah Matthews: Just for the record, where are the last two?

Dr. Joshua Tepper: The VON 360 Degrees in Peterborough, June 2011, for the deputy; and Waterloo Region-Kitchener, November 2011.

The Chair (Mr. Garfield Dunlop): Okay. That's all we've got time for in this round.

Mrs. Christine Elliott: Thank you.

The Chair (Mr. Garfield Dunlop): Now, Mr. Hampton, you've got the next 20 minutes.

Mr. Howard Hampton: I have some questions about air ambulance. Looking at my copy of the estimates book, which may be different from your copy of the estimates book, the estimate for 2010-11 for air ambulance is $138,225,800. Is that right?

Hon. Deborah Matthews: Just give us a second to catch up with you here.

Mr. Saäd Rafi: Which page?

Mr. Howard Hampton: In my book, it's page 141.

Mr. Saäd Rafi: Sorry. Thank you.

So we're looking at the standard account chart?

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Mr. Howard Hampton: Yes. It's $138 million. Is that right?

Mr. Saäd Rafi: Yes.

Mr. Howard Hampton: The estimates for 2010-2011?

Mr. Saäd Rafi: I read the same, yes.

Mr. Howard Hampton: And if you go back, the estimates for 2009-2010 were $132 million, and the actuals for 2008-2009 were $126 million.

Mr. Saäd Rafi: Yes.

Mr. Howard Hampton: Okay. Can you tell me just basically how air ambulance is provided in the province?

Mr. Saäd Rafi: Can we get someone who has that detailed expertise, if you'll permit?

Mr. Howard Hampton: That's fine.

Mr. Saäd Rafi: Okay. Perhaps while we're rustling that person up, would you like to move to a different question? I don't want to eat into your time.

Mr. Howard Hampton: My understanding is that there are three levels of air ambulance: critical, advanced and primary care. Is that right?

Mr. Saäd Rafi: Yes, I believe that's correct.

Mr. Howard Hampton: And most of that is provided by fixed-wing air ambulance—not all, but most is provided by fixed-wing air ambulance?

Mr. Saäd Rafi: I think you have me at a distinct disadvantage in that I don't have those details—

Mr. Howard Hampton: Okay.

Mr. Saäd Rafi: We're trying to find someone who can—

Mr. Howard Hampton: Sure. The questions are fairly basic. If you can't answer them today, I'd like a written answer.

Mr. Saäd Rafi: Sure.

Hon. Deborah Matthews: Okay.

Mr. Howard Hampton: Now, as I understand it, you also have to provide, in addition to the actual physical air ambulance, the dispatch for air ambulance, right? I believe there is a centralized dispatch for air ambulance.

Mr. Saäd Rafi: I believe that's correct, yes, and distributed dispatch for land because it's a municipal—

Mr. Howard Hampton: I'm interested in air ambulance at this point in time. Now, there's one thing I want to be sure of: Is the dispatch cost included in the $138 million? Because when I look at the way you've broken this down, further up in the standard accounts you've got transportation and communication. Right? So I want to know: Is the dispatch part of the air ambulance envelope? Is it included in the air ambulance envelope or is it part of the transportation and communication envelope?

Mr. Saäd Rafi: Understood.

Mr. Howard Hampton: Good. But whatever, I want to know what the dispatch cost is, because you should be able to break that out.

Mr. Saäd Rafi: Okay.

Mr. Howard Hampton: Now, I understand that you call the Ontario air ambulance service Ornge. Is that right?

Mr. Saäd Rafi: Yes, it is.

Mr. Howard Hampton: And Ornge is a—and correct me if I'm wrong, but I'm just going on what I've been told and what I've been able to read—not-for-profit entity. Is it a corporation? Is it a branch of the ministry? What is it?

Hon. Deborah Matthews: It is not a branch of the ministry. It is a separate organization and—

Mr. Saäd Rafi: Its legally constituted status—I want to make sure that I give you the right response, so I'll get you that legally constituted status.

Mr. Howard Hampton: Yes, I'd like to know. What kind of corporation is it? Is it a corporation with share capital, without share capital? What is it?

Mr. Saäd Rafi: Okay.

Mr. Howard Hampton: But I'm also told that the ministry funds 100% of the approved cost for air ambulance services, including air ambulance dispatch, through Ornge.

Hon. Deborah Matthews: I think we might have our air ambulance expert with us now.

Mr. Saäd Rafi: This is Patricia Li, our assistant deputy minister for direct services.

Ms. Patricia Li: Hi. I think you wanted to know some background about the air ambulance program?

Mr. Howard Hampton: Yes.

Ms. Patricia Li: We do cover 100% funding of the approved cost of air ambulance operations. This year, it's approved for $136.1 million.

Mr. Howard Hampton: One of the questions I had is, does that also include the air ambulance dispatch?

Ms. Patricia Li: Yes, it does.

Mr. Howard Hampton: So there are no costs associated with air ambulance that fall outside of that $138 million?

Ms. Patricia Li: That's correct.

Mr. Howard Hampton: That $138 million is totally and completely inclusive?

Ms. Patricia Li: Yes. It's through a transfer payment program.

Mr. Howard Hampton: Transfer payment?

Ms. Patricia Li: Yes.

Mr. Howard Hampton: And Ornge is the operator of air ambulance?

Ms. Patricia Li: Ornge is the operator.

Mr. Howard Hampton: What is Ornge? Is Ornge a not-for-profit corporation?

Ms. Patricia Li: Yes, it's a not-for-profit organization.

Mr. Howard Hampton: A not-for-profit organization or corporation?

Ms. Patricia Li: Corporation.

Mr. Howard Hampton: It is?

Ms. Patricia Li: It is incorporated.

Mr. Howard Hampton: Now, does it have share capital?

Ms. Patricia Li: No.

Mr. Howard Hampton: It doesn't. All right. Who runs Ornge?

Ms. Patricia Li: Dr. Christopher Mazza. He's the CEO of the Ornge corporation.

Mr. Howard Hampton: Of Ornge, the Ontario air ambulance service?

Ms. Patricia Li: Yes.

Mr. Howard Hampton: Okay.

Now, I have a question. If he is the head of Ornge, why does his name no longer appear on the Ontario salary disclosure list after 2007? This is the Ontario air ambulance service. It's 100% owned by the government of Ontario. He's the head of Ornge. Why would his name no longer appear on the salary disclosure list after 2007?

Mr. Saäd Rafi: Again, I'll have to consult with the Ministry of Finance, who are responsible for regulating and determining who is included and who is not, and we'd like to get back to you on that.

Mr. Howard Hampton: Okay. Well, that's Ornge. My understanding is that some of the air ambulance service, though, is provided by literally dozens of independent contractors.

Ms. Patricia Li: No, all air ambulance is actually operated by Ornge. When they were created—they do subsume some of the contracts from the previous ministry operations, so there may be some still left over that Ornge as an organization managed the contract.

Mr. Howard Hampton: Let me state it again so we're very clear. If you go to North Bay, if you go to Timmins,

if you go to Hearst, if you go to Geraldton, if you go to Sioux Lookout, Red Lake, Fort Frances, Kenora, you will find independently owned air operators who provide air ambulance to Ornge on a contract basis.

Ms. Patricia Li: Yes.

Mr. Howard Hampton: Yes. Okay. Now, what procurement process do they have to go through? It's my understanding they have to bid and they have to state what they've got available in terms of aircraft, etc., and capability. So what's the procurement process that they go through?

Ms. Patricia Li: They follow essentially the same as the procurement process of the Ontario public service. In fact, we actually finished an operational review of the organization, and the review assessment indicates that they have followed an open and transparent process for procurement of services.

Mr. Howard Hampton: And that's a standardized process?

Ms. Patricia Li: Yes.

Mr. Howard Hampton: So if you're a bidder from Timmins or you're a bidder from Geraldton or you're a bidder from Kenora, same process?

Ms. Patricia Li: I don't know—I think it's the same process, yes.

Mr. Howard Hampton: All right. Can I ask you, then: There's another entity called Air Ornge, or Ornge Air. Now, what is Ornge Air?

Ms. Patricia Li: My understanding is that Ornge Air is an affiliate organization under Ornge that actually provides the operations, the air ambulance—

Mr. Howard Hampton: But my understanding is that Ornge Air is a profit-driven corporation.

Ms. Patricia Li: I have to look into that. I don't know—

Interjection: We'll look into that.

Ms. Patricia Li: Yes. I will follow up.

Mr. Howard Hampton: If you could. I'd be very interested, because I'm told Ornge Air is a profit-driven corporation. Right?

Now, you've got all these small airlines from one end of the province to the other, mainly in northern Ontario, providing air ambulance. They bid; they go through a procurement process. Can you tell me, does Ornge Air go through a procurement process?

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Ms. Patricia Li: Yes.

Mr. Howard Hampton: Is it the same as the other providers?

Ms. Patricia Li: I'll have to look into that.

Mr. Saäd Rafi: I see the point you're driving at. We don't know its legally constituted status. If indeed it is a for-profit organization, we'd have to determine whether we govern its procurement processes and practices. I think as part of the response we will address both its procurement practices as well as its legally constituted status.

Mr. Howard Hampton: If you could answer some other questions, too. It's my understanding that Ornge Air has purchased several brand new high-tech airplanes, Pilatus airplanes. Someone told me they go for about $11 million a plane. Does the capital to purchase those airplanes come from the ministry?

Ms. Patricia Li: No.

Mr. Howard Hampton: Where does the capital come from to purchase those airplanes?

Mr. Saäd Rafi: They're a transfer payment agency, and again, if purchased through Ornge Air—I'm unfortunately not knowledgeable enough on its corporate designation, but since all funds are given through transfer payment dollars—in your question on dispatch, for example, you asked if it would be part of direct operating expenditures, such as transportation and communications; no, it would be under transfer payment. A transfer payment dollar out of the ministry may not—not in all circumstances—be designated capital or operating but designated as a transfer payment dollar, and the organization would then—and again, I need to check whether this is the case for Ornge—apply those funds either for a capital expense or an operating expense.

Mr. Howard Hampton: At the end of the day, though, what I want to know is, where is the money coming from to purchase what are, by any measure, pretty expensive airplanes?

Mr. Saäd Rafi: We'll have to get back to you with how they're financing that and what its status is, relative to the Ministry of Health.

Mr. Howard Hampton: I'm satisfied with your answer that all of the other air ambulance providers have to go through a procurement process. I want to be very clear on this: Does Ornge Air go through the same procurement process as the other providers? If it doesn't go through the same procurement process, what is the procurement process for Ornge Air?

Critical care—we've already settled that there are three kinds of air ambulance: primary care, advanced and critical care. I'm told that the critical care ambulance service, that category, was not offered through a competitive procurement process. I'm told that that is operated exclusively by Ornge Air. Can you tell me why something which we would all agree is fairly expensive wouldn't be offered through a competitive procurement process? Why would something be removed from the competitive procurement process? What are the policy reasons for that?

Mr. Saäd Rafi: I'm sorry; I'm probably going to exceedingly give you a similar response. Once we can establish the first principal question, then we will do our utmost to answer the follow-ons that relate to its status and therefore what it is obliged to follow with respect to rules and directives.

Mr. Howard Hampton: If in fact Ornge Air has not gone through a procurement process that is the same as the procurement process of other ambulance providers—and here I'm talking about advanced and primary care, not critical care. I've already separated out critical care; now I'm talking about advanced and primary care. My understanding is that all the other operators have to go

through a very thorough procurement process if they want to bid to provide an air ambulance service, and I'm told that Ornge Air doesn't have to. If I am right in that, can you explain why Ornge Air would not have to go through the same competitive procurement process that other operators would go through?

Hon. Deborah Matthews: Rather than answering a hypothetical question, what I'd like to do is get answers to the questions that you have asked. I confess to you that this is not an area I am well schooled in, and we'll do the work required to get answers to the questions that you've raised.

Mr. Howard Hampton: This is the general overlay question: I'd be very interested if you could give me the details on the nature of the relationship between Ornge air ambulance services and Ornge Air. Who is the head of Ornge Air? If it is a contractual relationship, if Ornge—which is the Ontario air ambulance service—contracts with Ornge Air to provide services, then I want to know the value of the contracts. I want to know them for critical, advanced and primary care. Who is the head of Ornge Air? Does it get its money exclusively through the Ministry of Health or does it have access to funding from some other agency or some other arm of the government? Because my understanding is that Ornge Air, the company, now provides a very substantial share of the air ambulance services to Ornge.

Hon. Deborah Matthews: We'll look into the questions. I think I know where you're going with this, and we'll get answers to you as we can.

The Chair (Mr. Garfield Dunlop): There are two minutes left in this round, Mr. Hampton.

Mr. Howard Hampton: Also, can you tell me if there is anyone who has a position at Ornge or provides services to Ornge in the nature of managerial/executive and also has a similar position or provides similar services to Ornge Air?

Hon. Deborah Matthews: So you want information on the relationship between Ornge and Ornge Air?

Mr. Howard Hampton: I'd like to know if anybody is getting paid by Ornge and Ornge Air both.

Hon. Deborah Matthews: Yes.

Mr. Howard Hampton: Thank you.

The Chair (Mr. Garfield Dunlop): Thank you very much, Mr. Hampton.

We'll now go to the government members, and you have 17 minutes this time.

Mrs. Liz Sandals: Mr. McNeely first.

The Chair (Mr. Garfield Dunlop): This is a 17-minute rotation, and then we'll go into the final three, okay?

Mr. Phil McNeely: Thank you very much, Chair.

I've been involved with the CCACs and with some of the seniors' homes in Orléans, talking about the aging-at-home issues, and they're all very interested. I believe this is a program that has been expanding over the years, and I would just like to know where it's at now, where it's going, how many seniors are involved, how we're going to deal with the great tsunami, as they call it. Just earlier, there were questions about the cost of aging at home and the cost of someone ending up in a long-term-care facility, the advantages of having somewhere for these people to go to rather than ending up at the emergency hospitals when their caregivers give up or they can no longer look after themselves. I'd just like to have an update on that, Minister.

Hon. Deborah Matthews: Thank you for the question. I think all of us know that as our population ages, we're going to have to change the way we deliver health care to our most vulnerable seniors in particular. We've been historically focusing on hospitals and on long-term care. We've added home care to the mix, but we know there's so much more we can do to take advantage of work that's already happening in the community.

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Keeping people at home as long as possible with the supports they need to stay at home is an area of real opportunity for us, and we're embracing that opportunity. But I have to say, we're in uncharted territory to some degree on how we invest in the community to support people staying at home as long as they possibly can. We've put $1.1 billion over four years into aging at home. This is money that is going to the LHINs, and the LHINs work with their communities, including their hospitals and their CCACs and their long-term-care homes, to understand what the challenges are in their community, and, more importantly, what the strengths are that they can build on in the community.

We've recently announced the expansion of aging at home. It will fund approximately 125 new programs, additional aging-at-home projects. This year, we're increasing aging at home by $143 million over last year, so a total investment of $330 million. It's sometimes difficult to explain exactly where that money is going, because it is different in different communities. But at its core, it helps seniors stay at home with things like rides to medical appointments. Sometimes what a senior needs is transportation to get the care they need. Sometimes they need help with household chores. Sometimes they need additional home care hours. What we're really trying to do is support seniors where they want to be, and that is in their home, that is in their community, it is with neighbours and family members, all part of their community. Supporting them as they age—aging is a very natural process, and we want people to be at home as long as they possibly can. That is good for people. It's also good for our health care system, because the cost of keeping someone in their home is usually less than the cost of having someone in a long-term-care home or in a hospital, certainly. So we're working hard to do that.

We also know that a great number of our emergency room visits are from seniors who, if they had the right care in their home or had the right access to care and the right supports, actually wouldn't need to go to the emergency department. We've got some wonderful examples of programs across this province, and they're tracking outcomes. They are really measuring the effectiveness of these programs, and we are seeing, in some of those

programs, a significant reduction in emergency department use.

I was at the health innovation expo last week and I met with the wonderful—it was an expo of innovation in our health care system. I met with people who are leading a nurse practitioner outreach team in long-term-care homes. The nurse practitioner actually comes into long-term-care homes and has a relationship with the nurses and the PSWs on staff. The nurse practitioner comes in when a patient is maybe showing signs that they need a little more care. The nurse practitioner can, over the phone—or go into the home and examine the patient. In this particular program, they had reduced ER visits by 97%. It was extraordinary, and that was a program funded through aging at home. In this case, the home was a long-term-care home, but this investment in the nurse practitioner outreach teams reduced the pressure on the emergency department.

I was in Barrie celebrating the initiation of a similar program. One of the programs: I met a delightful gentleman who had suffered a stroke some years ago and was in long-term care. He was getting all the care he needed; he was probably getting more care than he needed, more care than he wanted. He wanted to go home. So with the support of aging-at-home money, he now is in his own apartment. He has a personal support worker come in twice a day to make sure he's getting what he needs, the care he needs. He's now hooked up with a family doctor. He's got a nurse practitioner who helps with the circle of care. But he is very proudly independent once again and is exactly where he wants to be. And frankly, it's where the system wants him to be, because supporting him in his home is less expensive than supporting him in long-term care. By moving him from long-term care into his own home, we're freeing up a space where someone who really needs long-term care can then move into long-term care.

So there are some wonderful examples across the province. It's really making a difference, and I'm not for one second going to suggest that we have maximized the capacity of that initiative. We haven't. I know there's a whole lot more we can do by focusing on community and by providing a continuum of supports so that people get all the care they need.

I was recently at the opening of a 20-unit supportive housing building in London for people with acquired brain injuries. These were people who either were receiving 24-hour, seven-day-a-week care that they didn't need because they didn't need that level of care, or they were people who were living independently without the support they needed. There is no question that these people, now that they've got their own homes—they were very pleased. They've now got their own kitchen. They've got their own living rooms. They can have guests over. They have a home that is theirs. They have access to two full-time-equivalents of support, so two FTEs serving 20 people, preventing these people with acquired brain injuries from needing to access much more expensive care.

One of the residents of this new supportive housing is a 21-year-old woman who had been in a car accident and has an acquired brain injury. She had been living in a long-term-care home, and she transitioned from a long-term-care home to supportive housing and now she's moving into this. It is supportive housing, but for a large part it's independent living.

Those are the investments that we simply must make, and we want to do more in terms of supporting people so that they get the care they need but they have as much independence as they can possibly have, and that they're in the community with people and they're able to enjoy life to the fullest. It's an initiative I'm very proud of.

I really would urge all MPPs to sit down with their LHINs to understand the aging-at-home initiatives in their communities, because we hear in our constituency offices about people needing care. I think we'd all be well served by taking some time with the LHIN and learning about the aging-at-home initiatives in our communities. They really are making a difference for people.

Mr. Phil McNeely: Thank you, Minister. I'd just like to take a couple of minutes. Pierre Michaud came in to see me, and he is the president of Séraphin-Marion, a francophone seniors' club in our area. There's a second French seniors' home, Le Rendez-vous des aînés, and one bilingual, one English group, about 600 or 700 members. Altogether, they have 2,000 members.

They've been discussing things. They find their seniors are coming in earlier, and they're getting into lots of programs that involve exercise, the arts, reading. They want to expand that. I know there's a program through the seniors' ministry that gives the clubs that qualify about $50 per person per year. So he was suggesting to me, Mr. Michaud and the others on these organizations, that if we could get seniors more involved in some of the minor stuff and the companionship that seniors need—within a club they get that, and if they get into the situation where they need home care, then there's a good transition.

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He just asked me to mention that, so I'm mentioning that, getting that on the record today. But it seemed to me that seniors' clubs may have a role to play in the aging-at-home because that's their friends, that's their community, the seniors' club, especially these large clubs, and it should work out well. I just wanted to get that on the record.

Hon. Deborah Matthews: Thank you.

The Chair (Mr. Garfield Dunlop): We've got about five minutes left in this rotation. Mr. Brownell?

Mr. Jim Brownell: Okay. I'll take one and get on. I just want to say that in my riding of Stormont–Dundas–South Glengarry we've had many opportunities in the last little while to have some major capital projects come to fruition. Some are in the process right now; for example, the Cornwall Community Hospital. We had the Winchester hospital completed, which was a wonderful opportunity of providing, in a rural area, a modern facility with modern, up-to-date equipment. We never had in

rural Stormont–Dundas–South Glengarry a CT scanner. Now, in that hospital they made room for a CT scanner; it's operational and the like. I understand that in the new hospital in Cornwall we're going to have an MRI, which we've never had in eastern Ontario, which is going to be a great benefit.

I just listened to you a few moments ago about—I'll come back to that, but I just want to say thank you for commenting about aging at home. I've experienced that in my own life with my mother, who experienced aging-at-home supports for as long as she could age at home, then there came a point where she had to go to the hospital, where she is right now.

But, having said that, I know we've made a lot of investments in health care across the province, in buildings and in providing modern technologies in those buildings. I wonder if you could give us an idea of what kinds of investments? I just mentioned MRI machines and CT scanners, but I'm wondering if you give us any expanded information on what is transforming our facilities that are being upgraded to build modern health care opportunities in the province?

Hon. Deborah Matthews: I want to start just by acknowledging—

The Chair (Mr. Garfield Dunlop): You've got about three minutes on this—

Hon. Deborah Matthews: Okay. I'll try and do this quickly. Mr. Brownell has recently announced that he's not going to be running again next year, and I just want to express on the record my admiration for the work you've done in the time that I've had working with you. I have to say, I was really pleased to see in the newspaper that you remarked on the improvements in health care in your community as one of your proud achievements—

Mr. Jim Brownell: It was a top priority.

Hon. Deborah Matthews: The top priority.

Mr. Jim Brownell: Yes.

Hon. Deborah Matthews: So you've been an extraordinary advocate for your community and a wonderful colleague. We're not going to say goodbye yet, but I do want to say I was really pleased to see that improving health care—that we've made a difference in your community, working together. Thank you for that.

There is no question that when we came to office, our health care capital infrastructure, our hospitals and our other infrastructure had been very badly neglected. There was an enormous infrastructure deficit, and not just in health care, but of course the area we're talking about today is health care.

What we committed to back when we were elected in 2003 was to start to move forward, rebuilding the foundation of our health care system, including the infrastructure. We embarked on the most aggressive ever capital program. You can imagine there has been significant—there was a very long lineup of hospitals looking for an infusion of cash to bring their infrastructure up to modern standards. We've made some good progress. We're now working on the next 10-year infrastructure plan.

But the reality is, the hospitals that were built 50 years ago do not meet today's standards. The rooms are not built in a way to minimize infection rates, for example. So we're bringing into the new facilities design that actually has an impact of reducing infection rates. Our operating rooms cannot handle all the equipment that is in an operating room today. I've been in some operating rooms where there are wires all over the place and equipment that is actually a hazard for the people working in the emergency department.

We just haven't kept up with the significant problems around energy efficiency. I can tell you that we've really emphasized improvements to our emergency departments. As we work to bring those emergency department wait times down, those emergency departments needed to be physically changed to allow—for example, Ms. Sandals spoke about the fast track at the Guelph General Hospital, so where people come in with minor injuries, they go in one direction, they get the care they need quickly and can get on their way; other more complex cases go a different route. But the way they had been designed didn't facilitate the flow of patients, so we're investing, for example, in improved emergency departments. The technological changes have been massive, and we're responding to those.

The Chair (Mr. Garfield Dunlop): That's pretty well it for your round this time, ladies and gentlemen.

We'll now go to Ms. Elliott. We have about 13 minutes for each of the three caucuses to clean up, and we'll finish up this afternoon right at 6.

Mrs. Christine Elliott: Thank you, Chair.

Minister, my next question relates to the assistive devices program. As you're probably aware, they're currently facing a backlog of thousands of applications. Seniors and people with disabilities are waiting about six months or more for approval, and as a result, vendors have been providing them with equipment in advance of the approval just to ensure their mobility. But now we've got a huge backlog of applications, vendors waiting for reimbursement. Many of them are facing bankruptcy or are simply having to go out of business. And in the midst of this, I understand that the program laid off eight contract workers in May. They've currently hired six replacement workers, but there are still thousands of applications that need to be dealt with. Can you please advise me what the plan is to deal with this backlog, to keep these people from going out of business?

Hon. Deborah Matthews: I'm going to ask my deputy to respond.

Mr. Saäd Rafi: I'll try to give you an answer. I'm not sure I'll address the specific level of backlog. We're certainly attuned to the fact that the auditor and the public accounts committee have indicated to us that there should be augmentation of the staff in order to properly deal with the volume of claims, as well as the need to keep vendors aligned with their clients' needs, especially in smaller communities. To that end, we have invested in sound management structure, a dedicated director-manager and added 15 additional staff on a permanent basis.

We wanted to make sure that we would properly address those needs identified by public accounts and the Auditor General, and in fact, we've been invited tomorrow morning to the Standing Committee on Public Accounts to talk about those improvements and those changes.

We've managed to examine certain prices, we've managed to get better agreements with both vendors and authorizers, and we've created a modernization team to help address the backlog.

Perhaps Patricia Li, who is here, as I mentioned to you earlier, might speak to some of those improvements that we've managed to bring.

Ms. Patricia Li: We did do an assessment of all the claims in total within the assistive devices program, and we actually have been reducing the backlog numbers in the last three weeks. What we also have done is to have more temporary staff and contract employees, and added to the claims assessment staff resources about 11 FTEs. Our expectation is that all the backlog will be reduced by probably the first week of January.

Mrs. Christine Elliott: And the additional people have already been hired and are on the job now?

Ms. Patricia Li: Yes, they have been hired and they have been trained. There is going to be a bit of a learning curve for them, but we started the new staff three weeks ago.

Mrs. Christine Elliott: Thank you.

My next question—a different topic—is on homes for special care. As you know, they haven't had a raise in funding for some time. The current per diem is $47.75, and yet their costs are going up with the impact of HST and minimum wage increases. Can you tell me what you anticipate doing with respect to this and homes with special care that provide much-needed relief in the community for a very vulnerable population?

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Hon. Deborah Matthews: If you're asking what's going to be in the budget, I'm going to have to say that I don't know, and if I did, I couldn't tell you.

Mrs. Christine Elliott: So there's nothing currently planned, and we'll have to wait and see in the budget?

Hon. Deborah Matthews: Pardon me?

Mrs. Christine Elliott: So there's nothing currently planned with respect to homes for special care?

Hon. Deborah Matthews: We're going to have to wait for the budget.

Mrs. Christine Elliott: Similarly, with respect to CCACs: Do you plan to have CCACs join the ranks of other health care providers and be rolled into the 0% increase group?

Mr. Saäd Rafi: The union representatives, or the unions that represent workers in the CCAC sector—there have been discussions taking place with them, if I'm not mistaken—SEIU and others—through the Ministry of Finance and the Ministry of Government Services.

As far as the non-unionized broader public sector, yes, the government is expecting that their employers be able to adjust their budgets based on a zero-zero, two-year outlook for wage increases.

Mrs. Christine Elliott: What percentage of the overall workforce would that represent? The non—

Mr. Saäd Rafi: The overall health care workforce?

Mrs. Christine Elliott: In the CCACs.

Mr. Saäd Rafi: I would have to get back to you. I'm afraid I don't have that number.

Mrs. Christine Elliott: Okay. Can we get that breakdown?

Mr. Saäd Rafi: We will provide that, yes.

Mrs. Christine Elliott: Moving on to another topic: the pharmacy regulations. How would you respond to the fact that since the recent reductions to generic price in Ontario, some have said that the fact that there are drugs that are no longer available in the marketplace is attributable to the cuts imposed by the pharmacy regulations, and that it's no longer economically feasible for some generic manufacturers to manufacture and sell those products in the province of Ontario?

Hon. Deborah Matthews: I'm very happy to respond to this. I have to say that there are shortages of some particular drugs. That has always been the case and probably always will be the case. Because of issues in the plant or other supply issues, there sometimes are shortages. Pharmacists know how to handle those. They have absolutely nothing to do with our drug reforms. I was happy to see that the Ontario Pharmacists' Association and the Canadian association of generic drugs—I probably have that title wrong—verified that, that these are shortages that happen from time to time. The evidence might be that these are national or even international shortages; they're not specific to Ontario. There's no connection whatsoever between some of those shortages and the reforms to the elimination of professional allowances.

Another way you might want to think about it is that what we did was eliminate the professional allowances. This was a very large expense that the generic companies had to pay drugstores, or pharmacies. We actually, through our reforms, eliminated that expense for generics. They were not the sector that actually felt the impact of our reforms. That was more the retail pharmacy side.

There is also the issue of—there are some generic drugs where the manufacturer of those drugs will argue that they can't supply the generic at 25% of the brand price. They need more than that to actually make it viable for them to produce those generic drugs. We, in our legislation, allow for those special cases to be treated separately. They work with our executive officer to demonstrate that they need a price higher than 25% of brand in order to produce those drugs. That is a process that is ongoing now.

Having lower prices for generic drugs is of enormous benefit to us. Hundreds of millions of dollars will be saved to taxpayers. People who pay cash for their drugs will benefit; they will have lower prices. People who get their drugs covered through a benefit—insurance or a drug plan—will also see either lower premiums or more services for the same amount of money. The Generic Pharmaceutical Association has said that the shortages

are not related to the reforms, according to the Toronto Star.

Mrs. Christine Elliott: But are you aware—I've heard this from many pharmacists—that because generic products are not available, they are having to actually substitute brand name pharma products? So instead of lowering the price of drugs, it's actually raising the price. Are you aware that that's the case?

Hon. Deborah Matthews: Absolutely right. In the few cases where there is a temporary shortage of a generic drug, unrelated to our drug reforms, pharmacists may find another generic they can substitute, or they may have to substitute the brand. As I said, this is something that happens in the world of pharmacy, unrelated to our reforms.

Mrs. Christine Elliott: Well, because of this and because of these shortages—actually, quite a number of drugs are currently not available, a lot of them being antibiotics—there's a lot of concern right now that with the cold and flu season approaching, we're going to have a real problem on our hands because of the unavailability of these medications. What do you plan to do to address that?

Hon. Deborah Matthews: We're aware of shortages that occur from time to time. There is a process by which they notify the ministry that there is a shortage and we make arrangements. This is business as normal, business as usual for us in pharmacy.

My deputy has more to add.

Mr. Saäd Rafi: I just might add that if the reference was to vaccines, then there is a separate process we're engaging in with the federal government, along with other provinces, to ensure a consistent and effective supply of vaccines. The federal government leads that procurement process with the close participation of the provinces and territories to try to make sure that vaccines are available.

Mrs. Christine Elliott: Okay. Thank you. It was really more with respect to antibiotics than vaccines, but—

Hon. Deborah Matthews: You might also be interested in knowing that there was a concern that pharmacies would close as a result of the changes, and I can tell you that there have been some closures. Twenty-two pharmacies in the province have closed since July. On the other hand, 36 new pharmacies have opened, so we're actually seeing more access to pharmacy.

The other important point is that as part of our reform, we're now paying pharmacists to actually put their education and experience to work. We're significantly expanding the MedsCheck program to people who are in long-term care and to people with diabetes. We also have a new program called MedsCheck at Home for people who can't get to the community pharmacy. The pharmacist can actually go to their home, and we pay him or her for going to the home and opening up the medicine chest. They look at not just prescription drugs but also any over-the-counter drugs, including naturopathic drugs and so on, to do that evaluation.

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

Mrs. Christine Elliott: But, Minister, as you know, there are still some concerns with respect to the expanded professional services funding for pharmacy that was promised at the time the pharmacy regulations came in. Can you tell me when pharmacists can expect to get the funding?

Hon. Deborah Matthews: Absolutely. What we did, because we knew it would take time to ramp up the new services that pharmacists will be providing—we had $50 million earmarked for services; we added another $100 million. We're working with our pharmacy partners to get it right, to make sure that as we expand services, pharmacists will be able to provide them and they will provide benefit to patients. We're actually giving them another dollar on top of their regular dispensing fee as we make that transition. So my recollection is that it's $1 for the first year—

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Mr. Saäd Rafi: And it steps down over three years.

Hon. Deborah Matthews: —and it declines over a three-year period, I believe, as we phase in the new services.

It has changed for pharmacists, make no mistake about it. The old model, where they got the professional allowances for really doing nothing—those days are over. We're doing it over time to give them time to adapt, but we are absolutely committed to enhancing the role of pharmacists in our health care system. They have a lot of knowledge. We know that significant numbers of people coming to our emergency rooms are doing so because they're not taking the medications they've been prescribed properly, or it's a problem with a medication error. I'm very proud of what we're doing on that front.

The Chair (Mr. Garfield Dunlop): Okay, and that concludes the time for the official opposition.

Mr. Hampton, you have about 13 minutes.

Mr. Howard Hampton: I've just got a few questions. Have any analyses been conducted to assess the quality of care provided to someone by a for-profit home care agency in relation to the quality of care provided by not-for-profit home care providers?

Hon. Deborah Matthews: Make no mistake about it, we expect the very same quality of care from for-profit and not-for-profit providers of home care. I can tell you that we are working now on actually developing the appropriate metrics so that we can ensure that the highest quality care is being delivered to people obtaining that care at home.

Perhaps someone else could speak more to that and where we are there.

Mr. Saäd Rafi: The regulatory requirements, as well as patient safety and other requirements, are identical. They speak to what an individual resident and/or patient, dependent client, should expect. They're not different for the incorporated or unincorporated, for-profit or not-for-profit status of the organization.

However, in the home care sector, related to a previous line of questioning that you were asking about, we are working with all of the organizations that provide care to make sure that they are at a point where they can say that, should there be changes, should there be increases in the requirements of care or in the safety, they're able to step up and they know how to do that. That's effective training.

Mr. Howard Hampton: Let me make my question more specific. When Manitoba—this goes back I think about 10 or 15 years—went down the road of introducing profit-driven home care as opposed to non-profit home care, they commissioned a study by some people at Carleton University's school of public administration to compare profit-driven provision of home care with not-for-profit provision of home care. So the study was commissioned, and it actually looked at quality of service, cost and what the actual in-the-home providers were being paid—nurses, registered practical nurses.

My question is, has any such study or studies been conducted by this government?

Mr. Saäd Rafi: I need to check.

Hon. Deborah Matthews: Not to my knowledge and not to my deputy's knowledge, so we're going to have to check to see if there has been research done on that particular question.

But what I can tell you is, quality metrics—measuring quality, reporting on quality—is really our big focus right now. We're moving forward pretty aggressively when it comes to long-term-care homes. When it comes to hospitals, we're at the beginning of that quality process—

Mr. Howard Hampton: I'm more interested in home care, at this point.

Hon. Deborah Matthews: And home care is very much on our agenda. We'll find out if we've done any research on that particular question.

Mr. Howard Hampton: But your answer right now is, you don't think there have been any studies—

Hon. Deborah Matthews: Not to my knowledge, but a lot goes on in the ministry that I'm not aware of.

Mr. Howard Hampton: Are any studies being undertaken by the ministry to assess the total amount of home care hours required in each LHIN? In other words, have you sat down and tried to ascertain what the need for home care hours is within each LHIN?

Mr. Saäd Rafi: I would say that that is assessed based on each LHIN's partners in their geography, the funds available and trying to determine what the best supports are that can be provided. Should they be long-term care, should they be home care, and then what of the numerous numbers of programs, some that have been discussed today, aging at home and other seniors programs, other home care programs that have been and are in place—and have been in place for many years, in some cases—everything from assisting seniors with upkeep of their homes so that they can feel a little bit more independent, Meals on Wheels, right through to a nurse practitioner coming in post-discharge to help with wound care in the first week, which is a critical period of time to ensure that those things take place?

Again, I don't think there is one approach that should be or could be applied. These approaches are meant to be guided by the partners that deliver care in the community and the LHINs themselves, when they lay out the plan on an annual basis.

Mr. Howard Hampton: I would assume that if the LHIN is trying to do health planning, one of the things that they would want to get their head around is, what was the need level for home care this past year and what is the projected need level for home care this year. I can't imagine how the hell they would do budget planning if they didn't have their head around that.

Mr. Saäd Rafi: I guess what I'm saying is—perhaps now that I better understand—that is the methodology, such that you sit down and figure it out on an annual basis, one year ahead, as to what would the needs be, with ability to pay, and then, what services exist.

I think what has been mentioned here about aging at home is another example of trying to be as flexible as possible, geographically dependent. I was simply commenting on—

Mr. Howard Hampton: So do you have an overall number for the amount of home care hours, since I would think each LHIN—it seems to me that that would be one of the elementary things that each LHIN would do.

Mr. Saäd Rafi: Again, not at my fingertips. We'll have to do that across 14 LHINs, and we'll see if we can—

Mr. Howard Hampton: Can we get that?

Hon. Deborah Matthews: We'll see what we have.

I think it is important to note that we now have almost 200,000 more people receiving care than when we took office.

Mr. Howard Hampton: No debate there.

Hon. Deborah Matthews: We made significant improvements in home care. We've increased funding by 64%.

Mr. Howard Hampton: That's fine. I just want to know if you've got a number. If you have a number, if we could please have it.

But I also want to know this: How many hospitals are in deficit at this time? What is the aggregate total of their deficit at this time? How many hospitals are projected to be in deficit by fiscal year end? And what is their projected aggregate total of deficits projected to be?

Mr. Saäd Rafi: We are into the third quarter of the fiscal year 2010-11. There is an expectation that hospitals manage to have a balanced budget, and so we are—

Mr. Howard Hampton: But I read the local papers, and—

Mr. Saäd Rafi: We are constantly having conversations with hospitals when they identify challenges that they're facing, and we do work through those challenges with the LHIN, the hospital and the ministry, depending on if it's a capital or an operating issue. So until we get closer to fiscal year end, I don't want to presume that someone will find themselves in deficit when they may

not, because they may find ways to work through a one-time challenge that has percolated due to an increased volume in a particular department versus a decreased volume in another department. As you well know, there's an art to managing a budget.

Mr. Howard Hampton: Can you provide a list of hospitals that have received top-up base funding in the last 12 months, and the amounts they've received?

Mr. Saäd Rafi: Again, I'll note that and we'll do our utmost to try to get that answer.

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Mr. Howard Hampton: The 2010 budget papers indicate a 1.5% base funding increase for hospitals but an overall hospital funding increase of 4.7%. Can you give us a breakdown and amounts by hospital in each LHIN for base funding, on one hand, and for all additional funding on the other; for example, post-construction funding, high growth funding, wait times funding—the special categories, the special envelopes whereby hospitals might get additional funding.

Mr. Saäd Rafi: I believe Ms. Gélinas asked that exact similar question, and we're trying to compile that across 154 hospitals.

Mr. Howard Hampton: I just want to make sure.

Mr. Saäd Rafi: We've noted it.

Mr. Howard Hampton: Good.

I'd also like to know a full breakdown by hospital for emergency wait times funding, including physician initial assessment funding, ambulance off-load, nurses' funding et cetera. I understand those are all different envelopes.

Mr. Saäd Rafi: Yes, except that not all of the three you mentioned are discrete funding items. I don't believe physician assessment—if they are, we'll certainly do our best to provide those as well. By hospital, I take it?

Mr. Howard Hampton: Yes, by hospital. Within my own constituency I have some hospitals saying, "How come we didn't get that funding and they did?" I think it's creating some anxiety out there among different hospitals. You have one town here and another town 100 kilometres away, and somehow one got funding through special envelopes and the other one didn't. They're trying to figure out how that happened.

Mr. Saäd Rafi: We're not averse to putting in the time and effort; it's just that there are 234 hospital sites in the province, as you know.

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

Mr. Howard Hampton: I understand that you have the hospital accountability planning submission guidelines for 2011 and beyond—I guess they're called HAPS. When will the new guidelines for HAPS be released for 2011 and beyond?

Mr. Saäd Rafi: I'm sorry; I don't have that answer with me. I'll have to get back to you.

Mr. Howard Hampton: Okay. Finally, could I get a list of consolidations of services and programs, by hospital, in each LHIN. One of the things a LHIN was supposed to do was consolidate some services, some programs out of, say, four or five hospitals into one. I'd like to know what service consolidation has already happened and where. I'd also like to know what service consolidation is planned for the next fiscal year, since this is estimates, right?

Hon. Deborah Matthews: Each of the LHINs issues an annual report, and in each of those reports they list the integrations within the LHIN. So those are publicly available now.

Mr. Howard Hampton: But do they list them by hospital?

Hon. Deborah Matthews: Yes, I suspect they do.

Mr. Howard Hampton: That's what I'm interested in: by hospital.

Hon. Deborah Matthews: Yes, I'm quite sure it would say where the services were—

Mr. Saäd Rafi: It isn't always a hospital integration example. It could be a community integration example or an aging-at-home integration example. Where they report on those integration examples—it's on their website.

Mr. Howard Hampton: On their website?

Mr. Saäd Rafi: I believe so, yes.

Hon. Deborah Matthews: Their reports are on their websites, yes.

The Chair (Mr. Garfield Dunlop): That basically concludes your time, Mr. Hampton.

We now have another 14 minutes. Mrs. Van Bommel, you've got the first question.

Mrs. Maria Van Bommel: Thank you for being here, Minister. One of the things that comes up in a riding like mine, which is very rural, is the whole issue of access. One of the things that has been there for a while has been the community health centres. Something that is new and starting to come into my riding are the family health teams. I just wondered if you could explain for us the difference between a community health centre and a family health team—or are they essentially the same thing?

Hon. Deborah Matthews: Thank you for the question. I will give this my best shot. I probably will leave some things out, but I'll do my best.

The issue you raise—in a rural area, access is a different kind of question than it is in an urban centre, because we did not used to have the ability to actually direct geographically where practices would be set up. So doctors could set up practice wherever they wanted to live and wherever they thought they could get enough patients. Now, because of family health teams and nurse-practitioner-led clinics, we can actually make decisions about where those teams or clinics will be located based on where the need is the greatest. That's why if you look down the list of where our family health teams and our nurse practitioner teams are, you'll see they're opening in places like Omemee, Ontario. I was with Rick Johnson opening the Omemee family health team. I'm not sure that there would have been that kind of health care provided there otherwise. So we've got some levers that we didn't have before.

Family health teams are primary health care. They are a team of physicians and allied health professionals, including nurse practitioners, nurses, social workers,

dietitians, physiotherapists—a range of allied health professionals. A community health centre has the same. I think one of the differences between a community health centre and a family health team is, the family health team rosters patients, so you become a rostered member or patient of that family health team and you get your services there.

Community health centres are different in different parts of the province. Traditionally, community health centres have been located in urban centres and designed to serve a high-needs population. The community health centre in London, for example, is on Dundas Street East, a satellite in northeast London providing care to people who have high needs—high health needs, low socio-economic status, a high immigrant population. They're really designed to serve people who have been underserved by the health care system. But again, they do bring together a team of health care providers to provide support for people.

In other parts of the province, community health centres serve the general population and might be indistinguishable from a family health team. I was with Lou Rinaldi at a community health centre in his community, and they serve the general population of people in that community, but were located because it was an underserviced area. In that case, it was a hospital that had been closed down and has found new life as a community health centre.

They're different models, but they both provide holistic care to their patients.

Mrs. Maria Van Bommel: Thank you. Do we know how many family health teams we have in the province now? Do we anticipate having more in the near future? What's your sense of where they'll be located?

Hon. Deborah Matthews: We actually committed to opening 200 family health teams in the province of Ontario. We have now announced the final wave under that 200-family-health-team commitment. Many of those family health teams have many, many different sites, so when they're all up and running, three million Ontarians will actually be provided care through a family health team. It's really changed the landscape of primary health care in this province.

I can tell you that they're a very popular model, popular with patients and popular with the people who work there.

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I met a physician who's just graduating in family medicine, and he told me that he went to where he could find a family health team; he wanted to work in that kind of collaborative practice. He didn't really care where he went to practise, but what he did want to do was practise in a family health team model.

It's a model that is being embraced by our new graduates. They really like the collaboration and having a much wider array of expertise right there in that one place. They know that they can provide excellent primary care, but if somebody needs the services of another allied health professional—a dietitian, for example—there's a lot of comfort in knowing that there's someone affiliated with that family health team that will provide that care.

It's an exciting model. We've gone from zero to 200 in seven years.

Mrs. Maria Van Bommel: Certainly, I know in my own riding there's a number of community groups who are clamouring to have a family health team because of the fact that they've seen it in neighbouring communities and have seen what a success they are. The whole issue around recruitment of new physicians has been eased quite a bit by the fact that, as you say, many of the young graduates want to work in a family health team.

Thank you very much for your responses.

Hon. Deborah Matthews: Thank you.

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

Mr. Kim Craitor: How much time do we have, Chair?

The Chair (Mr. Garfield Dunlop): You have about six minutes left.

Mr. Kim Craitor: Good. Thanks. I have a couple of questions and for the record, I just want to share a couple of comments.

When I was first elected, before I was an MPP, I learned the best resource you have for getting information is the front-line workers. I just want to put on the record that I remember—and I still do it—I'd go down to the hospital, I'd go downstairs and have coffee with the nurses or any of the staff who were there. I remember asking them, "Why is our emerg so backed up?" They were explaining to me—especially the ones who have nursed for many years—"Kim, this is how it works. If I take you upstairs and walk around with you, I will show you that half the people who are in this emerg don't belong here. They come in because they want to get their prescription renewed, they come in because they have a cut in their finger, but this is where they go: to the hospital."

They were explaining me that at one time, hospitals were really emergency hospitals. When there were emergencies, they'd come in. But as time went on, it became almost like a walk-in clinic. Everybody just showed up there, so it built up.

What they said simply was, "The government has to look at a way of redirecting those people somewhere else so they can get the service, so we can get back to being what we were: truly an emergency hospital." What they told me—I never forgot this—they said, "Kim, what you've got to do is charge $10."

I said, "Oh my God, if I ever charged $10, they'd demonstrate in front of my office—$10 for every person who comes in there."

"Then they'd have an appreciation for health care. They'd at least think a little bit."

I said, "Well, that's never going to happen."

The only point I'm making is that when you talk about redirecting the physician-led clinics, the family health teams or the community health centres—I know from my riding, whether it's Fort Erie—and we have a Bridges out there that has over 2,000 people who are registered—or

Niagara Falls, between the community health centre and the family health team, we've probably got at least 3,000 who are registered between both of those who go there. We just got the new family physician-led clinic, and there's just an air of excitement; I hear it from the people in the community.

The point I'm making is that we're redirecting in the right direction, because we're offering a service—they should be entitled to it—but it doesn't have to be that you go to the emerg. The emerg can get back to being what it was: a true emerg.

I do have a question, though. This is to do with generic drugs. I want to tell you something: When we implemented this change to the generic drugs, just for the record, I personally probably visited about 30 pharmacists. I have to say that I learned a lot about what they do. It was far more than I thought, which was just renewing drugs. I learned that they give out a lot of great advice. They even call doctors when they look at a drug prescription and say, "I don't think you should be taking this because you're already taking this drug. I'd better call the doctor. I'd better check with him." So they do a lot of wonderful things that I didn't realize.

But I remember saying to them that we were doing this because we were trying to bring down the cost of drugs—because we are the largest purchaser of drugs—and there are people who pay for their own. And what we were going to do is reinvest it. It wasn't like we were just going to save money. We thought we were going to reinvest it and be able to cover other drugs that we have not been able to.

So the question is pretty simple: I just wondered, are we at the point where you can share that we've had some savings? And have any of those produced the fact that we've been able to cover some drugs that we haven't been able to yet because we had some savings with the reduction? Or is it still too soon to tell that?

The Chair (Mr. Garfield Dunlop): I'll give you a couple of minutes, Minister.

Hon. Deborah Matthews: Sure. I'll do this quickly. The round of reforms on drug pricing that we did just recently was actually round 2. Round 1 was in 2006 when we changed the pricing of brand name drugs. Since then, we've been able to fund 109 brand new drugs, 44 new cancer drugs and 62 new generic drugs. I'm going to give you just some examples; I happen to have them here. Gabapentin is for people with epilepsy. It used to be on exceptional access, and now it's covered under the formulary. A drug called Januvia for people with type 2 diabetes; Zeldox is now on the formulary. That's for people with schizophrenia and for bipolar disorder and other related disorders. There's a drug called Torisel, for people with kidney cancer, and Vidaza, for people with certain types of leukemia.

The pharmaceutical companies are engaged in significant research and trials. They are making extraordinary strides in allowing people to be treated through drugs as opposed to perhaps surgery or other interventions. These are drugs that keep people alive at a higher quality of life. We want to be able to add new drugs to the formulary.

Because of the savings that we will accrue and are now accruing as a result of our changes, we're able to add new drugs.

We're also able, as I said earlier, to expand the role of pharmacists. I actually met with a pharmacist in Ottawa last week. He told me he was a third-generation pharmacist. He was kind of thinking he might go into another career. With our changes, he said, "I'm now feeling rejuvenated. I think that there's now an opportunity for me to actually practise my full scope of practice." That's pretty exciting for pharmacists. I think that these are important reforms.

The Chair (Mr. Garfield Dunlop): Okay. That's great, committee. We're just right on time.

We have a few little votes here to clean up before we adjourn.

Hon. Deborah Matthews: Chair, actually, could I also take a moment before you get into that?

The Chair (Mr. Garfield Dunlop): Yes, sure.

Hon. Deborah Matthews: I just want to say thank you to our ministry staff, a team of people who have prepared all this information for us. They've done a wonderful job. I want to say thanks to the committee. You had some very interesting questions. The legislative staff, I really appreciate all the work that has gone into making this process work.

I also want you to know that we have been able to pull together answers for some of the questions that have been asked. We can share those with committee members and with the clerk.

The Chair (Mr. Garfield Dunlop): Thank you very much, Minister, and thank you also to the staff of the Ministry of Health and Long-Term Care.

We will now deal with the votes. Shall vote 1401 carry? Carried.

Shall vote 1402 carry? Carried.

Shall vote 1403 carry? Carried.

Shall vote 1405 carry? Carried.

Shall vote 1406 carry? Carried.

Shall vote 1411 carry? Carried.

Shall vote 1412 carry? Carried.

Shall vote 1413 carry? Carried.

Shall vote 1407 carry? Carried.

Shall the 2010-11 estimates of the Ministry of Health and Long-Term Care carry? Carried.

Shall I report the 2010-11 estimates of the Ministry of Health and Long-Term Care to the House? Agreed.

Thank you very much to all the members of the committee, and thank you once again to the minister, all the staff and to the research department here, and the Legislative Assembly staff.

With that, the meeting is adjourned and we'll meet tomorrow afternoon with the Ministry of Economic Development and Trade. Thank you.

The committee adjourned at 1800.

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Mr. Robert Bailey (Sarnia–Lambton PC)
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Mrs. Liz Sandals (Guelph L)

Also taking part / Autres participants et participantes
Mr. Ted Arnott (Wellington–Halton Hills PC)

Clerk / Greffier
Mr. Douglas Arnott

Staff / Personnel
Ms. Candace Chan, research officer,
Legislative Research Service