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## **Official Report of Debates (Hansard)**

**Monday 23 July 2012**

## **Journal des débats (Hansard)**

**Lundi 23 juillet 2012**

**Standing Committee on  
Estimates**

Ministry of Health  
and Long-Term Care

Office of Francophone Affairs

**Comité permanent des  
budgets des dépenses**

Ministère de la Santé  
et des Soins de longue durée

Office des affaires francophones

Chair: Michael Prue  
Clerk: Valerie Quioc Lim

Président : Michael Prue  
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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

## STANDING COMMITTEE ON ESTIMATES

## COMITÉ PERMANENT DES BUDGETS DES DÉPENSES

Monday 23 July 2012

Lundi 23 juillet 2012

*The committee met at 0801 in room 151.*

### MINISTRY OF HEALTH AND LONG-TERM CARE

**The Chair (Mr. Michael Prue):** Good morning. We are resuming consideration of the estimates of the Ministry of Health and Long-Term Care, vote 1401. There is a total of seven hours and 18 minutes remaining. When we concluded the last meeting, the minister had used 12 minutes of the 30 minutes that she has for a statement. That will be followed by statements or questions of up to 30 minutes by the official opposition and the third party.

Back to the minister: On the last occasion, you stopped at the end of page 5 of your prepared statement. I leave it to you, though. You can resume on page 6 for the benefit of people who were not here.

**M<sup>me</sup> France Gélinas:** Mr. Chair, do you have copies of the statement? This is it?

**The Chair (Mr. Michael Prue):** I have a spare copy.

**M<sup>me</sup> France Gélinas:** No, it's okay. I have—

**The Chair (Mr. Michael Prue):** You have one.

**M<sup>me</sup> France Gélinas:** Yes, I do. Sorry about that.

**The Chair (Mr. Michael Prue):** Just for the committee members, if the minister resumes where I think she will, that will be the top of page 6.

Madam Minister.

**Hon. Deborah Matthews:** I'm sure you've been anxiously awaiting all weekend long for me to resume my statement, so I will happily begin talking about the action plan.

We have achieved real and measurable improvements across our health care system, but we still have big changes to make. That's because we face some significant challenges—challenges that are inescapable, challenges that demand action.

The first challenge is fiscal: The province has a \$15-billion budget shortfall. That means we have to drive more efficient service delivery. With health care representing 42% of the budget, my ministry needs to do its share to return it to balance.

The second challenge is demographic: Ontario has a growing and aging population which is already putting more pressure on health care. The province is now spending 65% more on health care than it did in 2003, and health care spending will continue to grow. But the

fiscal challenge demands that we slow that growth significantly.

If we want to ensure that our universal health care system will be there for future generations, we need to act now to protect and strengthen the system. We need to make tough choices today, if we are to protect the system for tomorrow. We have to make those decisions based on the best available evidence, and they must add value. The entire health care sector will have to play its part to make it happen.

We know that we need to put more funding into home and community care to help the growing number of seniors stay at home as long as possible. The demographic pressure demands it. Indeed, by not having adequate resources in the community, we're spending more than we need to in other parts of the system. We must build the continuum of care in the community so that there are more options for seniors to get the care they need, outside of hospitals and long-term-care homes.

In January of this year, I launched our government's action plan for health care. It's a plan that will shift spending to where we get the highest value for investment and that will make Ontario the healthiest place in North America to grow up and grow old. The plan will transform health care to ensure that it is centred on the patient and will invest health dollars where patients will benefit the most. It will also limit year-over-year expenditure growth.

Our action plan has three key priorities. The first is keeping Ontario healthy, because people want better health, not just better health care.

My ministry is promoting healthy living and supporting better management of chronic conditions like diabetes. We need people to participate in their own wellness, and we're working to give them the tools to do that, in part by taking advantage of supports like cancer screening and vaccination programs.

We've already seen success with the Ontario diabetes strategy, where we built on existing capacity and made new investments to improve prevention and care of diabetes in Ontario. We've increased the number of diabetes education teams from 220 to 321, and established centres for complex diabetes care to provide specialized care and treatment. Overall, health promotion and diabetes prevention initiatives are reaching more than 40,000 Ontarians who are at high risk of developing type 2 diabetes.

Meanwhile, childhood obesity rates have skyrocketed, and we know that obesity leads to chronic conditions like diabetes and heart disease. That's why we must tackle this problem head-on. In May, I announced the Healthy Kids panel. It's a group of experts who will make recommendations to help us reach our goal of reducing childhood obesity by 20% over the next five years.

Ontario already has one of the best cancer survival rates in the world. We've got province-wide screening programs for colorectal, breast and cervical cancers that are helping to save lives every day. But this doesn't mean we can sit back and relax. The fight against cancer is an ongoing battle. That's why we committed to expanding these screening programs and to creating an online personalized cancer risk profile for all Ontarians. This profile will use medical and family history to measure the risk of cancer and then link patients to appropriate supports, screening or tests.

We're also addressing cancer, heart disease and other chronic illness through our tremendously successful smoke-free Ontario strategy. Under the strategy, 135,000 Ontarians have received supports to help them quit smoking in 2011.

We reaffirmed our commitment to the strategy by renewing it last spring, and we're enhancing supports. For example, the province will be providing free nicotine replacement therapy to those in treatment for addictions, and funds smoking cessation drugs.

We will continue our efforts to prevent kids from starting to smoke by increasing fines on those who sell tobacco to children, and will build on our contraband strategy by doubling our enforcement efforts.

The second priority in the action plan is providing patients with faster access and a stronger link to family health care. Working together with our doctors, we've done a lot already to give Ontarians better access to family health care. We now have 2.1 million more Ontarians with a family doctor.

What we want to do next is ensure that people who need care can see their primary health care provider, their family doctors, when they need them. This is critical to reducing pressure on other parts of the health care system, like emergency departments. That means making same-day or next-day appointments and after-hours care available when patients need them.

Our government believes that family health care should be the hub of patient-centred care, helping patients navigate the system, so we will work with our health care providers to strengthen the role of family health care in our system.

We also want to enhance the regional planning and delivery of care, giving a stronger role to the LHINs. After all, LHINs are the local managers of our health care system and play a critical role in local planning and accountability. We need to bring about a much more seamless patient journey across the health system: no more gaps in service, no more cracks for people to fall through.

We also want family health care providers to track quality improvement. My ministry will support the efforts of family doctors to improve patient care by giving them quality improvement tools similar to those now in hospitals, and primary care will be improved with evidence-based advice from Health Quality Ontario.

As you know, we are seeking a return to negotiations with the Ontario Medical Association for a new physician services agreement. Many of these system improvements form the basis of our proposals to the OMA. At the same time, we are determined to stick to a 0% increase in overall payments to physicians so we can invest in home care for 90,000 more seniors. I recognize and deeply value the contributions of our doctors. But they too will have to play their part to bring the province back to balance. That's why we're flatlining payments to physicians after the last nine years saw an 85% increase in billings.

#### 0810

Our action plan's third priority is making sure that patients have access to the right care, at the right time, in the right place. Access to the right care means ensuring that patients get the care they need, whether it's an MRI or a life-saving drug, based on the best available evidence. My ministry is going to accelerate the evidence-based approach to patient care by strengthening Health Quality Ontario so that funding is increasingly shifted towards services that are known to get the best results for patients. In 2011-12, evidence-based changes allowed a reinvestment of \$125 million towards more effective patient care. Patients will get access to care at the right time with early interventions that are clinically shown to improve health and save health dollars in the long run. For example, expanding our telemedicine network means more patients are able to benefit from faster care right in their own community.

Nowhere is early intervention more important than in mental health and addictions. Some 70% of mental health problems first appear in childhood and adolescence. That's why, through our comprehensive mental health and addictions strategy, there will be a focus on children's mental health. We took an important step by announcing \$11.2 million in funding for 144 nurses to work with mental health workers and school board staff to help students with mental health and/or substance abuse issues. We know that getting the right supports early decreases the impact of mental illness and addictions on people's lives and those of their families.

We will also continue to drive our wait times strategy so that patients can be assured of medically appropriate waits for their procedures. Less time waiting means fewer complications and more time for being healthy.

Finally, Ontario families need access to care in the right place. For our seniors, the right place to receive care, whenever possible, is at home, in their community. I recently announced the expert lead for a new seniors care strategy, Dr. Samir Sinha, a renowned geriatrician. He is developing a strategy that will keep seniors healthy at home, where they want to be, close to friends, neighbours

and family—and out of hospitals, out of ERs and out of long-term care.

As we announced in our budget, we will increase investments in home care and community services by an average of 4% annually for the next three years. That amounts to an additional \$526 million by 2014-15 to better support those seniors and other Ontarians who could benefit from care provided in the community.

We need to move away from our current provider-focused funding model and towards evidence-based, patient-focused funding that follows patients as they access the services they need, both in hospital and in the community. Since March, we've been working with hospitals to transition from a provider-centred funding model towards a patient-centred funding model, where funding is based on the services provided. Once hospitals adapt to this approach, we will all see better value for money and, more important, better-quality patient care. Patient-based funding will be phased in over the next three years, starting this year, 2012-13, in order to minimize disruption to services and impact on health human resources. Global funding will be reduced in proportion as patient-based funding increases. The phasing-in will allow health service providers to anticipate changes and plan for impacts on funding and services.

I now want to turn to our drug programs and how we're working to make them more fair, efficient and safe.

The Ontario Drug Benefit program provides assistance to all seniors for the cost of their prescription drugs. The ODB is a critical element of the health care services and supports that Ontario provides to seniors.

Since 2006, the government has made reforms to the Ontario drug system to improve value for both public drug programs and private payers. These changes include reducing the prices of most generic drugs to 25% of the cost of the comparable brand name products.

The savings in the ministry's drug programs were about \$500 million per year, by last year. An additional \$100 million in savings were achieved in 2011-12. These savings mean that we're able to fund more drugs for the Ontarians who need them. Since July 1, 2010, alone, 50 new brand name drugs, 36 new generics, and seven more cancer drugs are being funded. In addition, we have increased access to 82 drugs for new indications or as an expansion to general benefit.

We are taking steps to ensure that the ODB program is effective, properly administered and providing the most help to those in greatest need. The fairness of the program will be improved by asking the highest-income seniors—individuals with incomes over \$100,000, and \$160,000 for couples—to pay more of their own prescription drug costs, while ensuring that these costs do not impose an unreasonable burden. About 5% of ODB recipients will be paying more under this change. The changes will be effective beginning August 2014, to provide seniors with time to adjust to the new system.

We're also committed to ensuring safe access to drugs, particularly when it comes to prescription narcotics. The removal of OxyContin from the Canadian market this

winter highlighted the growing issue of prescription drug abuse in Ontario. We responded by restricting access to the tamper-resistant replacement, OxyNEO, by funding it through the Exceptional Access Program.

We expanded addiction treatment programs, information resources and monitoring for people who were misusing OxyContin through avenues such as:

- 24 new nurse practitioner positions in aboriginal health settings, half of which are helping support patients with opioid addictions;

- increased availability of telemedicine equipment for agencies that provide services to people with addictions, including working with Health Canada to increase use of telemedicine in First Nations communities;

- additional funding to purchase overdose prevention kits and training for front-line harm reduction workers; and

- streamlining the application process for Suboxone treatment, to ensure fast access for those who would benefit from it.

More recently, we reached out to the federal government to express our concerns about the generic form of oxycodone entering the Canadian market. Not tamper-resistant like OxyNEO, an even cheaper generic form would reintroduce the problems we faced with OxyContin.

All of these measures were taken with the best interest of patients in mind. We want better value in our drug programs while ensuring patients' well-being is taken into consideration at every step, so we can deliver a fair, efficient and safe drug system to Ontarians.

In conclusion, we have made substantial progress over the past nine years when it comes to improving the province's health care system. Today, we need to adjust our approach to strike a new balance, all the while continuing to work collaboratively with our valued health system partners. Without a doubt, there are challenges ahead, but there are opportunities too. This is the time to seize those opportunities for transformation to get better care for patients and better value for taxpayers. New investments must focus on promoting healthier living, on reducing the time patients wait to see their doctor, and on enhancing home and community care.

The ideal health system we want to achieve with the action plan is sustainable, patient-centred, evidence-based, and promotes quality, all while providing the care people need today and tomorrow. When we've achieved our vision, Ontario will be the healthiest place in North America to grow up and grow old.

Thank you for your attention. I'd now invite your questions.

**The Chair (Mr. Michael Prue):** And thank you. That was almost exactly 20 minutes.

The time is now for the official opposition. You have up to 30 minutes for either questions or a statement or a combination of both. I recognize Mr. Leone.

**Mr. Rob Leone:** Thank you, Mr. Chair, and thank you, Minister, for spending some time with us today. It's probably going to be a pretty long day with you. We have

a lot of questions, certainly, of a ministry that is, as you've mentioned, rather large, enormous. From that perspective, and in asking questions, for us, it's kind of like, where do you begin? Where do you start? How do you pinpoint where to unlock and unravel some key issues and information that would be helpful for our scrutiny of your ministry? Certainly, that is an important function that we have as the opposition here.

**0820**

I don't want to speak for my colleagues, but I'll speak for myself: From the outside looking in, this ministry seems to be, since it's very large and very enormous, chaotic, from the outside. I'm wondering if you could give us an indication of whether, from the inside, it is as chaotic as it looks from the outside.

**Hon. Deborah Matthews:** The answer to that is no. We have an extremely capable, competent and focused team of ministry officials who work very, very hard to make the system work.

I'm joined by my deputy, Saäd Rafi, today, and I'm sure he'll want to speak about the structure of the ministry.

What I can tell you is that Ontarians are blessed to have the health care they have. Is the system perfect? No, it is not. Can we do better? Absolutely. I outlined our vision for the future, to actually drive better-quality patient care, faster access to care and get better value for money. In order to do that, we need all parts of the system working together. I think many people will say that they get excellent care once they get into the system. It's the hand-offs between parts of the system, when people leave hospital to go home, for example—that's where we're really working hard to build the bridges between different parts of the health care system, and that work is happening.

You think about our seniors strategy. We've now got Dr. Samir Sinha, who's our expert lead on our seniors strategy. His work will cut across all parts of the health care system to make it work for people. That's really the next frontier in health care reform: to make the system work for people, to break down the silos between the ministry.

I don't know if the deputy wants to talk more about the number of ADMs, the responsibilities they have—

**Mr. Saäd Rafi:** Certainly. Thank you.

The span and scope, as you mentioned, is broad, but the approach that we've taken is really not that dissimilar to other ministries, by breaking down major programmatic and financial areas. We have probably one of the most seasoned and experienced executive teams, some of which were in place when I arrived. Some have been subsequently added or replaced as people move on to other opportunities and other interests.

We take a very disciplined approach to the financial aspects of the ministry. We've now started a monthly review; the financial part of that was quarterly, because of course we report quarterly to central agencies, especially finance, on our budget. We have managed to hold the line on spending and transfers such that two years

ago, government was spending about 6% in growth on health care; in the fiscal year 2012-13, it will be 2.3%. That's a dramatic change, but we are working quite diligently to try to manage that growth amount by working with the major transfer payment partners. One of the keys to that will be implementing, as the minister mentioned in her remarks, a health system funding reform, which starts with moving towards an activity-based funding model. Many of you will be familiar with activity-based costing. That's one way, in the hospital sector, to try to make sure that we can apportion costs for the services that people need, as opposed to apportioning costs for the service provider, which has been historically the approach that has been taken.

**Mr. Rob Leone:** That is good information, and thank you for that. But one of the reasons why people from the outside see your ministry as being chaotic is the number of instances where large boxes of information—the brown envelopes that are circulating, the ones that are passed off to ourselves and probably to the NDP as well—we see that a lot, coming from your ministry, particularly with Ornge. We're seeing it now in other areas as well, eHealth being one of them. Doesn't that seem chaotic? We're talking about bureaucrats in your ministry handing information to us, probably against your own will. Doesn't that give the image of chaos? And how do you account for that? What's going on in your ministry? How is the morale amongst your bureaucrats if they feel the need to get around your authority and pass on information to us?

**Hon. Deborah Matthews:** The first thing I want to say is that we are all striving to make the system stronger, and we are always open to knowing what needs to be done to make the system stronger. I would encourage you, invite you, to actually work with us to make the system stronger. If you have information that comes to you, I trust that you will share it with us, to ensure that that information is put to good use, that that information does work to achieve what I think is our shared goal, and that is best possible value for money and highest-quality patient care.

We will continue to work with opposition. I think as long as there is government, there will be opportunities to improve it.

**Mr. Rob Leone:** I think the issue here, Minister, is that folks in your ministry, rather than coming to you directly, are coming to us to get to you. That's why people think there is chaos. The fact is that they're sidestepping your authority somewhat, coming to us and giving information about different things—not me personally, but certainly members of our caucus. That's why I think people think that there is a bit of chaos in your ministry, because they're not coming through the chains—they're not going to your deputy minister; they're not going to you. They're coming to members of the opposition to try and shed some light on some of the problems within your ministry.

Why do you think that is? Is it just that they don't see the authority of yourself or your deputy as being import-

ant enough? Is it because of perhaps a perceived lack of willingness to listen to your bureaucrats? What is the reason why we're getting so many folks coming forward with information that has come out through public accounts, that has been asked through question period—information that should, I think, be going up the normal bureaucratic chain. Rather than doing that, they're coming to us. Why do you think that is? Is it just because they think that you don't listen? What's the issue there?

**Hon. Deborah Matthews:** You're building questions based on information I don't have, so if you would be prepared to share the information that you have been given, I can then respond to it—

**Mr. Rob Leone:** Well, Minister—

**Hon. Deborah Matthews:** But what I can do, Mr. Leone, is ask the deputy to talk about the processes within the ministry that do actually foster that spirit of quality improvement, value improvement. We have made significant progress in transparency. We now publicly report information that, under previous government, was hidden. The Auditor General now has the ability to go places where he never was able to go before, and we have benefited from that. We've got transparent information on outcomes. Wait times, for example: We now know what wait times are for virtually every procedure in virtually every hospital in the province. That was not something we had under the previous government. So we have fostered a culture of transparency, of continuous quality improvement.

I can tell you that my experience is that our ministry officials are driving hard to improve health care for the people of this province and improve value for money. There are more formal processes, I'm sure, and perhaps the deputy could speak to that.

**Mr. Saād Rafi:** I would just like to underscore that the ministry is actually, somewhat uniquely, a group of very passionate and dedicated individuals who have spent their entire careers in the field of health care, either as practitioners and then moved into a policy realm or an operational realm, or have been on the policy/operational side for many, many years, and they work in all corners of the province.

I think that we have tried to foster increased access, added freedom of information into the hospital sector. The minister mentioned wait times and the transparency of wait times and the auditor's role.

**0830**

In addition to that, a very strong employee engagement and inclusion approach: I meet with a committee of voluntary leaders of all levels within the ministry who dedicate their time, as I mentioned, on a voluntary basis to try to improve employee engagement and inclusion in the workplace. That's an area that is very important to the management team and especially myself. These are areas that are going to bring continued engagement with staff, dedication and, I would say, increased responsibility and accountability that come with such a significant portfolio as health care. I think everybody has a view about the health care that they receive, and I think people at the

Ministry of Health are quite committed in trying to provide those services in a way that speaks to the integrity of public service.

**Mr. Rob Leone:** You both mentioned a goal: certainly, a mission to be transparent. I'm wondering if you would be willing to provide the committee with all of the correspondence between your political staff and the Premier's office related to the Ornge scandal.

**Hon. Deborah Matthews:** Are you making a motion? Or how does this—

**Mr. Rob Leone:** I'm asking a question.

**Mr. Vic Dhillon:** Mr. Chair, if it's a motion, we'd like to have a copy and have a look at it.

**The Chair (Mr. Michael Prue):** It's not a motion. He just asked a question. He did not use the word "motion"; it's just a question.

**Hon. Deborah Matthews:** The committee is entitled to get the information they ask for, so if you give us some more parameters on what time frame etc., we'll do our best to accommodate the will of the committee.

**Mr. Rob Leone:** Great. If the will of the committee is to ask for all correspondence related to eHealth sent between July 18, 2012, and July 23, 2012, between your political staff in the ministry, bureaucrats and eHealth Ontario employees, would you be willing to provide that as well?

**Hon. Deborah Matthews:** As I said, we would certainly do our best to get the information this committee wants.

**Mr. Rob Leone:** And if the committee decides to request access to your House book, would you be willing to provide that as well?

**Hon. Deborah Matthews:** Again, I would say, let the committee ask for information and we will do our best to get that information for you.

**Mr. Rob Leone:** Minister, the PC caucus is currently waiting for a number of responses to FOI requests, many of them filed more than six months ago, with respect to these items. That's why we're asking the question: If it is a goal of your ministry to be transparent and we've requested them through freedom of information, do you believe that it would be a responsibility of your ministry to provide that information through freedom-of-information requests?

**Hon. Deborah Matthews:** As you know, freedom-of-information requests do not go through my office. They are dealt with by the ministry, so I will turn to the deputy for a response on that question.

**Mr. Saād Rafi:** Forgive me, I don't know the exact request because we track them by the type of request. I'll try to find out their status.

**Hon. Deborah Matthews:** I think it's also important to add that we have significantly expanded access under freedom of information. For example, hospitals now are subject to freedom of information. I can say that we have learned information through that that I think demonstrates the importance of transparency.

**Mr. Rob Leone:** Minister, we have undertaken to receive documents from the Ministry of Energy in the

past—during this session, actually. In response to that request for information and documents, the Ministry of Energy and the Ontario Power Authority provided us with a letter. That's what their response was.

**Mr. Vic Dhillon:** It's got nothing to do with it.

**Mr. Rob Leone:** It does, and I'm leading up to that, Mr. Dhillon. The reality is, I'm hoping that through the motion that we passed last Thursday, we won't be getting a similar response, with respect to a one-page or two-page letter in response to those documents that we've requested. Would that be accurate?

**Mr. Saäd Rafi:** Absolutely. I would just reiterate, though, through the Chair, that the scope of the request is quite large. We've received it; as you well know, it has been voted on. We've already proceeded to start working on it. We appreciate that the time frame was a little bit better than in other motions that we've received, so we will be providing the materials that we can based on the approach that the committee has taken.

**Mr. Rob Leone:** Okay. Thank you for that. I have some questions with respect to other comments that were made in the opening remarks. One that particularly piqued my interest was on page 6, this third sentence here that says, "The first challenge is fiscal. The province has a \$15-million budget shortfall. That means we must strive for more efficient service delivery."

I'm wondering if you could give us some information with respect to eHealth Ontario in terms of how much it has cost the province of Ontario—just give us a general number—and the progress that you've made, with particular reference to eHealth Ontario.

**Hon. Deborah Matthews:** Absolutely. We are enormously proud of the progress that is being made at eHealth Ontario. We now have about 60% of our family doctors and 40% of community-based specialists with EMRs. That, of course, is the first part, a foundational building block of a full electronic health record. We continue to be on track to have EMRs for all Ontarians by 2015. We've made remarkable progress in getting those electronic medical records in those offices.

We also have made extraordinary progress on parts of eHealth that aren't always considered by the public to be eHealth. The Ontario Telemedicine Network is a global example of the possibilities of telemedicine. We've got people in parts of Ontario who would have had to travel a great distance to see a specialist and would have had to wait a long time to see those specialists, who are now getting access to that care right in their own community through telemedicine and eHealth.

The ENITS is another terrific example of where eHealth is saving us money. ENITS is the emergency neuro image transfer system, where, for example, if someone had a car accident and damage to their head in Owen Sound, they could have the scan done there and would be able in real time to transfer that image to a neurosurgeon specialist available 24-7 who would be able to talk to the attending physician, see the image and make a determination about whether that patient should be transferred or not. That system has paid for itself and

more by avoidable transfers. You can imagine, if someone has an injury in Owen Sound, the last thing you want to do is transfer that patient. What we are doing now through ENITS is, we're preventing and avoiding those unnecessary patient transfers.

So eHealth is a very important part of how we're going to be able to improve health care under more restricted fiscal growth, and we are making significant progress on that front.

I think you asked for the cumulative since the inception of eHealth Ontario. I don't know if you want to go back to the pre-eHealth days under how far back we can go, but perhaps the deputy has been able to get that information.

**Mr. Saäd Rafi:** I only have with me four fiscal years, so from 2009-10 to the current, so the budget for fiscal 2009-10, 2010-11, 2011-12—sorry, the actuals—and then the budget for 2012-13. We've seen a reduction in spending due to efficiencies and the reduction of use of various resources like consultants. In 2009-10, the agencies spent \$267 million; 2010-11, \$365 million; and in 2011-12, \$410 million. Budgeted for 2012-13 is \$521 million. That includes both operating and capital, approximately two thirds operating, one third capital.

**0840**

**Mr. Rob Leone:** As a question of interest, your ministry health-based planning briefing books: The notes that I have here—I don't have a page number, unfortunately—say transfer payments to eHealth Ontario are different figures than the figures you just provided. Are there additional payments that aren't considered transfer payments to eHealth Ontario that were part of—unfortunately, I didn't write the page number down, to know, but my numbers here say 2010, \$321.4 million; 2011, \$369.5 million; and 2012, \$376.5 million, which were a little lower than what you just provided me. My colleague Michael Harris is looking at the specifics. Is there an additional cost other than the transfer payments, then?

**Mr. Saäd Rafi:** No, and I apologize for that. My numbers seem to be off from what you're quoting by a small amount, so we will reconcile those. I thought I had publicly reported budget numbers—I think they are. We'll try to get that reconciliation or explanation.

**Mr. Rob Leone:** Minister, you stated that 60% and 40% of doctors in different categories are up and running on EMRs. How many doctors do we have in Ontario?

**Hon. Deborah Matthews:** Twenty-six thousand.

**Mr. Rob Leone:** How many of those doctors would be on EMRs and have access to provide—

**Hon. Deborah Matthews:** Let me get those numbers for you.

**Mr. Rob Leone:** The numbers that I have here state that there about 9,000 doctors on EMRs. I'm just trying to find out where I have that number from. I think this is a number that you've publicly disclosed. I think it might even be in your briefing notes, in your opening statement.

**Hon. Deborah Matthews:** So, 9,000 physicians, with nine million patients, are participating with EMRs. I just want to clarify that those are the family doctors. That is

9,000 of the—I'll get you the number on how many family physicians. Well, we can do that math pretty quickly, right?

**Mr. Rob Leone:** Oh, super-fast.

**Hon. Deborah Matthews:** So, 13,000 family doctors, and 9,000 are on—about 60% of family physicians.

**Mr. Rob Leone:** Okay. We've spent well over a billion dollars since 2009-10. The Auditor General reported in 2009 that we had spent a billion dollars on electronic health records for the total span—that included a number that was part of even what our government stated, and you've stated that publicly as well. So there has been a billion dollars spent prior to 2009. Now we have more than a billion dollars, perhaps getting closer to a billion and a half dollars, since 2009-10 on eHealth. What do we have to show for it?

**Hon. Deborah Matthews:** What we've got is nine million out of 13 million Ontarians with electronic medical records. We've got, in some parts of Ontario, linkages now being created between various health care providers. ConnectingGTA is a very, very important initiative of eHealth Ontario, where the five GTA LHINs are linking all of their hospitals, all of their long-term-care homes, all of their community care access centres. I believe 700 providers are feeding in to ConnectingGTA.

I think it's very important to focus, of course, on the cost but also on the enormous benefits. Once we have fully functioning, linked electronic medical records for Ontarians, we will have tremendous savings in reduced unnecessary duplicative testing. We will have significantly reduced costs related to medication errors, for example. We will have patients with much smoother transitions in the health care system. They will not have to repeat their story to every new provider that they deal with. We will have linked records.

We will also be able to use that information to better plan our health care system. We'll know where the overlap is, where the duplication is. Currently, one example of the success of eHealth Ontario is that all of our imaging in hospitals is digital, so when you go to a hospital, they will be able to access your images from previous visits. In many parts of the province now, all of the records from the region are stored in one repository. In southwestern Ontario, the South West LHIN and Erie St. Clair LHIN are joined. All hospitals in those two LHINs are able to access images of individuals.

The savings are enormous. We must invest in eHealth if we want to take advantage of the technology that's available to improve patient care and improve value for money.

**Mr. Rob Leone:** Minister, you stated that 40% of family physicians are part of that. My number is closer to 35%, but that's okay.

**Hon. Deborah Matthews:** Sixty percent of family physicians.

**Mr. Rob Leone:** Sixty percent of family physicians—representing nine million Ontarians?

**Hon. Deborah Matthews:** Yes.

**Mr. Rob Leone:** So that is roughly three quarters of the population of the province.

**Hon. Deborah Matthews:** Well, 60%; yes.

**Mr. Rob Leone:** How do you arrive at the nine million Ontarians? Is it simply a proportion? Are these the most industrious physicians, the ones that are participating, therefore more Ontarians and physicians, in terms of proportion, are actually covered under eHealth? The number, as I recall, probably several months ago, perhaps a year ago, was that half of Ontarians were on electronic medical records. Now we're saying nine million Ontarians are under electronic medical records, which is a lot more than half. I'm wondering how we got from six and a half million to nine million and how you can account for that number. Where do we get the number nine million?

**Hon. Deborah Matthews:** Why don't I get you the answer to that? But I think if we've got 9,000 physicians at 1,000 patients per physician, that gets us to nine million. But let me get you the assumptions behind that number.

**Mr. Rob Leone:** Okay, so that, in its essence, is not an accurate number. It's a calculation based on—

**Hon. Deborah Matthews:** I will get you the foundation for that number. I think the deputy—

**Mr. Saïd Rafi:** Just a small point would be to say that the growth in EMR physicians has been conscious by eHealth Ontario and OntarioMD, who is their partner. That is a branch of the Ontario Medical Association. In working with the Ontario Medical Association and the section of family physicians and eHealth Ontario, that number is meant to continually grow such that we will get a greater and greater proportion of family physicians on electronic medical records and then use the other tools that have been mentioned thus far to connect those records to create an electronic health record across the province, be that through telemedicine, be that through a drug profile viewer where every Ontario drug beneficiary has the ability, when they present, if they present at an emergency room or an emergency department—that the attending physician would see the drugs that they have been prescribed through ODB, which helps in a quick assessment and triage of the individual. We want to link those records together, and that's what the EHR piece is doing. The number of family physicians with an electronic medical record is meant to continually grow to hopefully get everybody.

**Mr. Rob Leone:** If 9,000 family physicians are on electronic medical records, you're saying 40% of specialists are with—

**Hon. Deborah Matthews:** Forty percent of community-based specialists—some specialists are hospital-based, so 40% of community-based specialists.

**Mr. Rob Leone:** I just wanted to make that clear. I wonder if you could comment on a comparative analysis of e-health systems within Canada and around the world. We are currently about, from your numbers, nine million patients—we have 13 million Ontarians—which is, you said, about two thirds to three quarters there. Other coun-

tries, other jurisdictions like the UK, are at 99% with their electronic medical records. Why is the Ontario situation so problematic? Why are we so far behind everyone else in the world with respect to uptake on our electronic medical records?

It seems to me that we're spending an awful lot of money, billions of dollars. We're at \$2.5 billion spent, covering only a small portion of our patients, yet we don't have full uptake yet. I'm wondering how much it's going to cost to get everyone up and running, and why we're lagging everyone else in the world.

0850

**The Chair (Mr. Michael Prue):** I'm sorry, you're going to have to answer that in the next round. The half-hour is now up.

Ms. Gélinas, it's your turn.

**M<sup>me</sup> France Gélinas:** Good morning, Minister Matthews.

**Hon. Deborah Matthews:** Good morning.

**M<sup>me</sup> France Gélinas:** My questions are in a different direction this morning. I will start with a little bit of northern health. The first one is, do you keep track of how many of the small and rural hospitals—small and rural won't only be northern; they'll be wherever they are in Ontario—are currently in a budgetary deficit position or are expected to be in a deficit position?

**Hon. Deborah Matthews:** What I can tell you is that—and the deputy will get a specific answer—one of the great successes of the LHINs has been to work with hospitals to get appropriate accountability agreements and driving to balance. Overall in Ontario, we actually have a surplus amongst our hospitals. As we move to patient-based funding models to fund our hospitals, we are excluding those small hospitals, because the function they serve in their community is different. We want to work with those smaller hospitals to drive efficiencies, but that formula, we don't think, is the right formula for those small hospitals.

I wonder if we're able to break it down by type of hospital.

**Mr. Saäd Rafi:** Not at my fingertips. We'd have to survey the 152 entities, or actually—yes, entities, I suppose; not the locations.

I can say that there were 122 hospitals in the fiscal year 2011-12 of the approximately—I think there would have been 154 at that time that had a total surplus of \$518 million; and thirty hospitals in 2011-12 had a deficit in total of \$44 million, so just a little over \$1 million, on average, per hospital. I don't have a breakdown by region, let alone by hospital, but if you would like that or need that, then we will produce it in the follow-up.

**M<sup>me</sup> France Gélinas:** The numbers you just quoted me, the 122 that were either balanced or surplus and the 30 that were in a deficit position: That's from 2011-12, the year that just went by?

**Mr. Saäd Rafi:** Yes.

**M<sup>me</sup> France Gélinas:** Of the budgets that have been submitted for 2012-13, do you have any idea if we are in the same range or if things are getting better or worse?

**Mr. Saäd Rafi:** I would say that the trend has been to see a greater surplus in hospitals and reduced deficits over the last four or five years. It's hard to predict what will happen at an individual hospital, in terms of who presents and what issues they may have; to know, going into the fiscal year, or even halfway through the fiscal year, as to whether they will be generating a surplus or not. But we do work with them, come the end of their fiscal year, to get that roll-up.

I would say that the Ontario Hospital Association would quite proudly say that they are the most efficient set of hospitals in the country, and I think our recent experience with them demonstrates that that is probably the case.

**M<sup>me</sup> France Gélinas:** I hear a lot about that \$518-million surplus from hospitals. Where does it go? And where does it sit right now?

**Hon. Deborah Matthews:** We do currently allow hospitals to retain that surplus or accumulate the deficit because we don't want to remove incentives to be efficient. I think that is an issue, though, as we see these surplus numbers to be very significant numbers. We do have to take another look at that policy.

Perhaps the deputy could speak more to that process.

**Mr. Saäd Rafi:** There will be certain times where we do get recoveries from hospitals. Sometimes we might flow them cash to get at a certain point at the beginning or the end of the fiscal year. We are working with them on provincial budget 2011—or maybe 2010; I'm sorry, I can't remember offhand—announced that we would be working on the working capital deficit that is cumulatively held by hospitals. We're in the throes of implementing that, such that we've assessed hospitals on how they've used working capital, and in some cases that has been deemed to be not consistent, but all have followed generally accepted accounting principles. So we're trying to reconcile the working capital deficits to get those to a point where they should be. As the minister said, if we see significant surpluses continuing, we'll have to examine our existing policies.

**M<sup>me</sup> France Gélinas:** Of the 30 hospitals that accumulated \$44 million, you will be able to let me know where they are and if they're part of the small and rural hospitals? Can I have the actual names listed so I don't have to look through?

**Mr. Saäd Rafi:** Sure.

**M<sup>me</sup> France Gélinas:** Thank you. The next question has to do with, during the budget negotiations we had asked for a \$100-million fund for northern and rural hospitals. That was our ask; we never got it. But we did secure an agreement that \$20 million would be invested in what is now called a transformation fund for small, rural and northern hospitals. I just want a little bit of clarification as to who is in and who is not; as in, is it solely for the rural hospitals in the north? Can the five big hospitals in the north have access? Do rural hospitals that are not in the north have access?

**Mr. Saäd Rafi:** We are working with a few organizations to determine how best to deploy those funds, which are, I believe, \$20 million—

**M<sup>me</sup> France Gélinas:** Yes, they are.

**Mr. Saäd Rafi:** So, for example, we're working with the Ontario Hospital Association's small and rural hospital caucus—I'm not sure if they call it a caucus, but their group—

**M<sup>me</sup> France Gélinas:** Association, yes.

**Mr. Saäd Rafi:** Association—within the OHA. In addition to that, we're working with the North East and North West LHINs and also with Dr. Roger Strasser, the dean of NOSM, to come up with transformational but also lasting—that will require hospitals to do something that connects them to the community. The consensus that is emerging is that they want to, especially in the north-east and northwest—I don't need to tell you—make sure that there's a continued and increased bond between community services and hospital services, of which they would probably be able to demonstrate a great deal in their experience, relative to other jurisdictions in the province.

We have not yet secured how to flow that and where, but, yes, we are looking at small and rural, and need to get an agreeable definition as well beyond the north, because I believe the budget says small, rural and northern—that's not a quote—so there's an “and” in there that suggests to us that it applies beyond the north.

**Hon. Deborah Matthews:** But if I could just add, I think it's wonderful, and thank you for giving us that focused money that will drive transformation. We know, and you know better than most, that as health care gets better, the role of hospitals in those smaller communities changes, and we must be proactive about that. We would be very happy to work with you—I would be very happy to work with you—as we develop how that transformation will be accelerated with that additional investment.

**M<sup>me</sup> France Gélinas:** From what you said, Mr. Deputy—and, thank you, Minister—is that you are planning a rollout plan but the plan is not all finished?

**Mr. Saäd Rafi:** Correct.

**M<sup>me</sup> France Gélinas:** Will it be something that will be accessible, as in, will I know, once the plan is finished, what's in it, what's not, or who will have access to that final plan to know what's in and what's not?

**Mr. Saäd Rafi:** We can certainly make that available, as the minister said. In fact, I think she's probably gone one further and invited you to provide that input. Yes, for sure, we would be happy to communicate that throughout the region. I think the North East and North West LHIN leadership has been quite open about their approaches in the community, both at the CEO and the board level, as well as, I think, the leadership within those hospitals, which I hope has been your experience as well.

0900

**M<sup>me</sup> France Gélinas:** Yes, many of them have come to me already.

**Hon. Deborah Matthews:** I think we'll find that \$20 million doesn't go—

**M<sup>me</sup> France Gélinas:** Very far.

**Hon. Deborah Matthews:** —all that far. But we've got other opportunities on transformation. That's a big part of what the ministry is driving right now.

**M<sup>me</sup> France Gélinas:** You talked about the shift to funding by procedure. From a briefing I had—you had offered a briefing, and I took it—we got a document that showed that 91 out of the 152 hospitals will either receive the same amount of money or a lesser amount of money as they transition to the funding per procedure. You don't call it that way; you call it—

**Hon. Deborah Matthews:** Patient-based funding.

**M<sup>me</sup> France Gélinas:** —patient-based funding, thank you. Of those 91, do they know who they are?

**Mr. Saäd Rafi:** I thought the number was 96—not to quibble, but just to be accurate.

**M<sup>me</sup> France Gélinas:** It could be.

**Mr. Saäd Rafi:** Some will also get an increase; you said a decrease or the same.

They absolutely know who they are. They absolutely know how much they are going to get. We are working with the hospitals, through numerous committees of experts, not just hospital individuals. We want to roll out the overall approach, which we call health system funding reform, to CCACs and long-term-care homes in subsequent phases.

So the hospitals know who they are. They know their allocation. They know, if they were going to grow, that they've been limited to 2% growth, or a 2% reduction if they have to become a little bit more efficient. That's a purposeful ban being put in place. We have been working very closely with them for months and months.

**Hon. Deborah Matthews:** And not only do they know how much they're going to be affected, they also know why. My experience has been that hospitals, even hospitals that are being negatively impacted, understand why and are working to become more efficient. So in fact, with this shift from historic global funding, where nobody could unravel the rationale of why a certain hospital had a certain budget, people now understand why they're getting what they're getting and what they need to do to become more efficient. It is having the desired effect.

**M<sup>me</sup> France Gélinas:** Just to make sure that I understand the numbers right, out of 152, 96 would be affected by the new payment model that you're rolling out. Out of those 96, my numbers show that 91 of them would either stay the same or be in the bracket that goes down 2%, and very few of them are actually increasing. Did I get this wrong, or am I close—

**Mr. Saäd Rafi:** I should probably correct the record. I foolishly said 96; you might indeed be correct. I apologize for that—

**Hon. Deborah Matthews:** Hold on. Fifty-five hospitals are excluded. The small hospitals are excluded, which leaves 91 hospitals included in the reform.

**M<sup>me</sup> France Gélinas:** Okay.

**Hon. Deborah Matthews:** Because we have had a merger—

**Mr. Saäd Rafi:** Yes, because there are some mergers. That's why 96 comes down to 91. Nevertheless—

**M<sup>me</sup> France Gélinas:** So 91 are included in the reform.

**Hon. Deborah Matthews:** So 91 are included in the reform. Some 63% of hospitals will see gains, and 90% of hospitals will see no more than a 1% swing in funding. We have put that band in place. The largest decrease is 1.5%. The largest increase is 1.8%.

I will just confirm these numbers. These are the most recent numbers that I have, and I will just confirm that these are in fact the most recent numbers.

**Mr. Saäd Rafi:** The reason for some small fluctuations is that how we recognize revenue and how hospitals have booked that revenue and how they account for their money is a continual process for us to sort out with the hospital. Throughout the course of the fiscal year, there might be ups and downs that would vary by fractions of a per cent. That's why there are certain numbers that, at the time we briefed you, we would have given you as the number of the day. Hospitals have come back to us and said, "No, hang on a second. Our audited financials have said X, Y and Z." So we've committed to make both beginning-of-year and in-year adjustments, if needed. This is not a matter of penalizing communities, or individuals in those communities—

**Hon. Deborah Matthews:** In fact, what's really important about this is that we're changing the incentive structure within hospital funding. We used to have a system where hospitals would close down the operating room for two weeks in the summer in order to meet their budgetary targets. They would restrict access to meet a budget. We think the right incentive should be: Provide the care the people in your community need, and you will be paid for that. So we're shifting the compensation structure to reflect the activity that is being performed in those hospitals.

Ontario is not a leader in this. In fact, Ontario is kind of late coming to this change in funding for hospitals, and we've learned from the experience of jurisdictions that have done this before us.

**M<sup>me</sup> France Gélinas:** Okay. I would be interested in getting the more up-to-date numbers that you can share with me, that show, of the 91 hospitals that are included, how many are getting an increase—

**Hon. Deborah Matthews:** Fifty-seven are getting an increase.

**M<sup>me</sup> France Gélinas:** Sixty-seven are seeing an increase?

**Hon. Deborah Matthews:** No, 57—63% of the 91.

**M<sup>me</sup> France Gélinas:** Okay, it's 57 hospitals; got you. Do I take it for granted that 91 minus 57 means 40% are seeing a decrease or stay the same?

**Hon. Deborah Matthews:** Yes, 37%.

**M<sup>me</sup> France Gélinas:** And of that 37%, how many are decreasing versus staying the same?

**Hon. Deborah Matthews:** We will do our best to get you those numbers.

**M<sup>me</sup> France Gélinas:** I would appreciate that.

**Hon. Deborah Matthews:** Okay.

**M<sup>me</sup> France Gélinas:** I'm still trying to focus on the north for a little while. The Northern Health Travel Grant: This is something that is used very much for the people I represent, and a lot of people in the north. During the election in 2011, there was a promise that was made to bring the Northern Health Travel Grant online. It's certainly something that got a lot of press in northern Ontario, where a lot of people use them. I was wondering how this is coming along and when we can expect this to be done.

**Hon. Deborah Matthews:** Deputy?

**Mr. Saäd Rafi:** I'm sorry; I don't have a sort of estimated time of having that complete, but it is something that we have to turn our minds to. We have not completed the exercise of not just putting it online but examining other elements that could be looked at, increased, improved in how we administer the travel grant.

We've had some successes with not utilizing the travel grant, because we've been able to provide diagnosis and services within the community, such as over 1,100 telemedicine sites that serviced about 144,000 Ontarians, at the latest figure. So we are trying to use other ways than dislodging someone from their community, and all the stress and concerns that go with that, including the family upset that that causes. That's why we're trying—

**Hon. Deborah Matthews:** I think also there was a time when it took a long, long time for people to get reimbursed for their northern travel. The ministry has done a very, very good job, tightening that time up, so 95% of applications are processed within three weeks. There are no applications taking more than four weeks. The ministry really has done a terrific job in reducing that processing time for those travel grants.

**M<sup>me</sup> France Gélinas:** Coming back to the online, is there someone within the ministry presently working on this, or is it a plan that is to come in the future?

**Mr. Saäd Rafi:** I don't know, off the top of my head. I certainly know the division responsible. I don't know the individual who might be developing the policy work on that. I apologize.

**M<sup>me</sup> France Gélinas:** Okay. If we don't have a date, do we have a time frame as to when you hope that this process would be accessible online?

**Mr. Saäd Rafi:** I do not.

**M<sup>me</sup> France Gélinas:** No. Okay.

**Mr. Saäd Rafi:** It will have to go through decision-making and also other considerations. I would not want to give you set expectations that I have no line of sight on as to whether they're on track at this point.

**Hon. Deborah Matthews:** I take it from your questioning that you think it's a good idea and the sooner the better.

**0910**

**M<sup>me</sup> France Gélinas:** Yes, I do, and yes, I do.

**Hon. Deborah Matthews:** Okay.

**M<sup>me</sup> France Gélinas:** There are two lines of thought out in northern Ontario. I agree with you that the use of telemedicine is increasing, I would say, exponentially in

northern Ontario—the number of sites, and people becoming more and more comfortable with the technology. At the same time, there still seems to be a huge demand for the northern travel grant. I was wondering if we could have access to the number of requests that have been done and—I have no idea if the ministry looks at this—from which communities they are coming.

Anecdotally, I could rhyme off a few communities where people seem to be sent out of town an awful lot. Others, I would guess, have embraced telemedicine a little bit better and tend to be doing better at keeping people in the north, I agree with you, where they want to be. But this is just hearsay. I don't have the data; I'm hoping you guys do.

So I'm asking as to, do you know how many requests, where the requests are going up, in which communities they are going up—and that's the request for the Northern Health Travel Grant.

**Hon. Deborah Matthews:** We will undertake to get you that information.

I think the other important piece is, now that we have a medical school in the north, in Sudbury and Thunder Bay, we're seeing more and more pretty complicated procedures that are able to be done in the north, where not too long ago people did have to travel to the south.

**Mr. Saād Rafi:** We'll have to search that information because I don't think we readily capture by community. We'll get that information for you—both number of requests and from which community?

**M<sup>me</sup> France Gélinas:** Yes, with an idea of, if we can have a little bit of a trend. The people who handle telemedicine are very good. They send me—and, I'm assuming, every MPP in the north—every three months, we get a chart that shows how many times the telemedicine network has been used, from which community. It's very useful. I don't remember requesting it, but it comes every three months. Here it is—and it is by area. It would be helpful and useful to have something similar to this, but that would be for the request for the Northern Health Travel Grant, to see how it's used.

If you are looking at the Northern Health Travel Grant, is any energy going to be put into looking at what it really costs people versus how much the government is reimbursing? Is this something that you have any intention of looking at?

**Mr. Saād Rafi:** It's hard to assess what it costs that individual because people use different means and methods. We have a strength of caregivers in the province; we may have people who have family connections—all manner of different things. Sometimes costs can be understated, sometimes they can be overstated, so it's really hard to predict, "We're reimbursing X per cent of actual total costs," because I think the actual total cost is very elusive.

**M<sup>me</sup> France Gélinas:** Let me point you in a direction. Gas is at \$1.34 in Sudbury this morning. When the Northern Health Travel Grant was set, gas was at 78 cents a litre; it is now \$1.34. A lot of people using the Northern Health Travel Grant drive. They used to drive,

paying gas at 78 cents a litre, and they now pay—I suppose once you're down south, you guys pay about \$1.21, \$1.27, I'm not too sure, depending on where you live. Sure, you can fill up once you get to your appointment, but you still have to fill up before you leave for your appointment. This certainly is a direct cost that has gone up substantially while the cost of reimbursement has not. Was there ever any thought given to linking those two? They don't have to be linked weekly, because the price of gas fluctuates an awful lot—but more than once every 10 years, some place in between?

**Mr. Saād Rafi:** Yes. We're not quite that slow. I believe it did go up in 2007, but fair point; point made. We'll look at that as part of the review.

**Hon. Deborah Matthews:** I'm taking it that this is an area where you think we should increase spending.

**M<sup>me</sup> France Gélinas:** This is an area where I think we should look at the real cost. If the cost of travel—I mean, people from the Cochrane corridor used to use the train to come down to Toronto. There won't be any; there is no more train. Ontario Northland is being cancelled. For the frail, a train is very comfortable. It allows you to make this eight-hour drive even if you're frail; it's comfortable. Once this is no more, then those people will rely on cars more and they will rely on the bus, if they are capable of enduring a pretty rough bus ride.

It's really to link the real cost. As things move, as government makes decisions that affect the ability of people in the north to go to their appointments in the south, it would be nice for the Northern Health Travel Grant to be linked into what's happening to the people who use the program. If the price of transportation—as I say, flights: We now have Porter that comes to the north. I used to pay 600 bucks for a one-way ticket to come to Toronto. I now pay 97 bucks. Porter has allowed us to have way cheaper flights. I can see no reason to give somebody \$600 if you pay for a \$97 ticket, but at the same time, if you use other modes of transportation, to be a little bit more responsive—we're now in 2012. Last time you looked at the reimbursement, it was five years ago. Things have changed for the people using the program.

I'm just curious to see if you do anything to try to address what will be the demand, or if you just respond to the demand. Is there any planning at the ministry level that looks at what will be the demand for the Northern Health Travel Grant, linking the different programs? I made an allusion to the telemedicine that does allow people to stay home. Do you link those two at any time?

**Mr. Saād Rafi:** We will for sure because, as I think you've agreed, we would prefer to see an uptake in the Ontario Telemedicine Network as well as other such things as ENITS, as the minister has talked about. There are many other technology changes that are coming and that are coming on stream.

We will have to do that because, of course, if you keep pace with the cost of goods and services, that cost to deliver that service is going to increase. Hopefully, if the volume reduces, then we have a chance to keep within

our 2% growth figures. So yes, for sure, we will be doing that.

**The Chair (Mr. Michael Prue):** You have about two minutes left.

**M<sup>me</sup> France G linas:** Man, that goes by fast.

If there is planning going on, is this something that is either FOI-able or is this something that is shared? How do we—I'll speak for myself: How do I find out that, "Yes, this has been looked at, and here's what we found?"

**Mr. Sa d Rafi:** When we are at that juncture, then we could perhaps give an offer to brief you. That juncture being through the minister, cabinet and other decision-making steps, we'd be more than pleased to brief you and any other northern MPPs who might be interested in what we're proposing, what we've come up with.

I am reminded by staff that some of the IT challenges are to get our system such that we can accept some of the personal health information that comes with this in an electronic form—a paper form is one thing. That's our current step in terms of when it's going to be coming online. We have some significant work to do on what we call the PHI, personal health information, IT database or IT elements—that's back to your previous question—but we would be happy to talk to you about what we're taking in and take your comments today to include in our review.

**The Chair (Mr. Michael Prue):** About 20 seconds.

**M<sup>me</sup> France G linas:** I guess it's the clerk who follows up to make sure that the questions that were not answered this morning will be answered in writing.

0920

**Mr. Sa d Rafi:** Yes.

**M<sup>me</sup> France G linas:** Do we have a date?

**Mr. Sa d Rafi:** We did hear from—sorry.

**The Chair (Mr. Michael Prue):** In general, it's 30 days, after which a reminder is sent.

**M<sup>me</sup> France G linas:** Thank you.

**The Chair (Mr. Michael Prue):** The minister now has up to a half an hour for rebuttal or a statement if she wishes.

**Hon. Deborah Matthews:** And I do wish. I believe that members of the committee have received a slide deck. Oh, you are about to receive a slide deck.

**The Chair (Mr. Michael Prue):** It is your time. The clock has been going since they were handed out.

**Hon. Deborah Matthews:** Oh, I apologize.

What I wanted to do is take kind of a higher-level overview of how far we've come in nine years. I think at the very centre of our health care system has to be, how are patients doing: Are they getting the care they need? They need to guide the decisions we make, the programs we fund, the services we deliver, and timely access to health care is at the crux of this. Ontarians deserve the best care when and where they need it. Ontarians pay for our health care system. It is designed for them. It is their system, and it is up to those of us who work in health care, who have the privilege of working in health care, to make the system work for patients.

When we came to office, we were faced with a broken health care system. In fact, we had a health care system that was teetering on the brink of two-tier. I can tell you that as an elected official, as someone who spends time going door to door talking to patients, the 2003 campaign made it very, very obvious to me that we had serious problems in our health care system. Talking to my colleagues who were campaigning in 2003, they heard the same things I did, right across this province. It was virtually impossible to get a family doctor. When people needed a procedure done, cataract surgery or hip replacement surgery, they waited literally years in pain in the case of a hip replacement, with their vision impaired in the case of cataract surgery. They waited years to get the procedure that they needed.

We had a brain drain in Ontario. Doctors were leaving this province because Ontario was not a good place to practise medicine. We were training and losing doctors. We have now reversed that.

Hospital deficits were out of control. There was no appropriate oversight of hospital budgets. I don't make the claim lightly that we were on the brink of two-tier health care. I had a lot of people arguing that they should be able to pay their way to the front of the line; that their mother should not have to wait in pain if they could afford to pay for that procedure. Of course, shorter wait times for them would mean longer wait times for everyone else.

So we went to work and have made some remarkable improvements. One of the things is—and you can turn to slide 3—we have significantly increased the number of doctors who are working in Ontario. In 2003—well, you can see for yourself on this graph. There was an increase—in some years, a decrease—in the number of doctors working, and we have got significantly more doctors—3,400 more doctors—working in Ontario than in 2003. We've got 12,600 more nurses and 1,000 more nurse practitioners than in 2003. We have reversed the brain drain. Last year, we licensed a record number of doctors.

We have also worked very hard to improve access to care. Some 2.1 million more Ontarians now have access to a family doctor, thanks to our efforts and the commitment and the dedication of our physicians, so that now 93% of us do have a family doctor.

These results did not happen by accident. They are the result of deliberate changes and investments by our government since 2003.

We've added 260 new first-year undergraduate medical spots. We've opened the Northern Ontario School of Medicine in Thunder Bay and Sudbury. We've opened satellite medical campuses in Windsor, Kitchener-Waterloo, St. Catharines and Mississauga. We now offer the most training positions and assessments for international medical graduates, more than all other provinces combined.

We now have 6,264 internationally trained doctors practising in Ontario. They are a very important part of our health care system. More than one quarter of our

physician workforce is actually doctors who were trained outside of Canada.

We've had an increase of 13% more family doctors and 18% more specialists than in 2003.

We're also working hard to connect patients to primary care, through our Health Care Connect service. Health Care Connect is for people who don't have a family doctor. They can register with Health Care Connect. They are connected with a nurse, who understands their health care needs and connects them with family doctors or nurse practitioners who are taking new patients and who can meet the needs of those patients. We have matched more than 150,000 people through Health Care Connect. It is proving to be a tremendous success.

We're also helping Ontarians find the most appropriate care, as close to home as possible, through the Health Care Options website and phone number. The Health Care Options website is one where you can enter your address or your postal code; you can indicate how far you're prepared to travel; you can click on the box on what kind of care it is you're looking for; and it will tell you—it's powered by Google Maps, so you actually see in your community where that care is that you need. Whether it's a family health team, a nurse practitioner-led clinic, an after-hours clinic, a walk-in clinic, you can find out information in your community. We have significantly expanded Health Care Options. What we learned is that people who work in health care knew about them but the public didn't. So now, through this website, we're able to teach people about what options are available in their community, in many cases preventing a visit to the emergency department. I put in my own address at home in London, and I was surprised to see what services were available, if someone needed stitches or an X-ray, that might prevent a visit to an emergency department.

#### 0930

A part of what we have done, as well, is we've created 200 family health teams in Ontario. They are providing care to 2.8 million Ontarians. This is a model of care that I can tell you the patients very much appreciate, the interdisciplinary holistic care that they get at a family health team. I can tell you that the health care providers very much enjoy working in an environment where they can turn to other health care experts who have expertise that they might not have themselves to get people the care they need.

These are interdisciplinary teams of health care providers. They include doctors. They include nurses, nurse practitioners. They include registered dietitians, pharmacists, social workers and other health care providers. The care depends on the community, so they have a plan of what kind of care they want to provide. They look at the resources in the community and they bring in the health care professionals who can provide that comprehensive care.

On the slide, what you can do is see what has happened here. This is a result from the Health Care Options website that shows what is available right in this neighbourhood. You can do that in any neighbourhood in the

province of Ontario. If you haven't already done it, I urge you to do it and I also urge you to make sure that your constituency staff are familiar with Health Care Options, because it truly is a wealth of information and starts to make sense of the health care system for people.

Another very important innovation in Ontario is our nurse practitioner-led clinics. We've created 26 nurse practitioner-led clinics, NPLCs. Twenty-three of them are open, seeing patients. The others are on their way. Some of them that are open—I see Kim Craiton nodding. He and I actually had the honour of visiting a nurse practitioner-led clinic in Niagara Falls. It's a very exciting innovation in health care. When these 26 NPLCs are up and running, they will serve 40,000 Ontarians. Again, patients who are taking advantage of the NPLCs are very pleased with the care that they are getting from nurse practitioners in their community.

On family health teams, just so you get a sense of the scope of them: 2,400 doctors are associated with family health teams and 1,700 interdisciplinary health care professionals; as I say, nurse practitioners, social workers, dietitians and so on are part of those teams.

The NPLCs, again, work as an inter-professional team. They focus on providing family health care. Some offer obesity programs, smoking cessation programs, cancer screening programs, provide house calls and access to care for patients when they need it.

As we look forward to innovation in our health care system, one thing that we are very committed to doing is increasing the scope of practice for our health care providers. We need all of our health care professionals working at their full scope of practice, and that's why we've expanded the scope of practice for a range of health care professionals. The winners are the patients, because patients will be able to access the care they need from the appropriate professional.

Some of our health care professionals have been very highly trained but unable to put that training to work. We are changing that. Nurse practitioners are now allowed to prescribe drugs, set a fracture, order X-rays, use ultrasound. Pharmacists have benefitted from increased scope of practice. I can tell you, some of you will remember, that there was a time when pharmacists were not particularly happy with this government. That is changing dramatically as we increase the scope of practice for pharmacists.

When we eliminated professional allowances, our commitment to pharmacists was that we would now start to pay them for providing care to patients. We eliminated the professional allowances, but we are now paying pharmacists to provide services that are important to patients.

MedsCheck has been an extraordinary success. MedsCheck is available to people who are on a number of different medications, who are being discharged from hospital, who live in long-term-care homes. What we know is that having that right management of medication is essential to the health of patients with complex conditions. So we now are paying pharmacists to review

medications for patients. That can be done in their office, in their pharmacy—or we now pay pharmacists to actually go into people's homes. If they can't come into the pharmacy easily, the pharmacist will be paid to go into a home to review all of the medications, including over-the-counter medications, so that people are taking the right medications at the right time. The pharmacist is putting their very extensive training to work. In many cases we're finding, once a meds check is done, that people are actually taking more drugs than they need. So it's actually reducing the number of medications that people are required to take.

We are excited about further expanding the scope of practice for pharmacists. We're looking at giving pharmacists the ability to provide immunizations for people over the age of five. That is a recommendation that is out for consultation right now. So we see a continually expanding role for pharmacists.

Midwives also are able to now do things through their scope of practice that they had been trained to do but were not allowed to do until we expanded their scope of practice. Of course, when it comes to midwives we're very excited. We are seeking proposals now to open stand-alone birth centres so that women who are giving birth to a child will have an option to give birth in a clinic. Their options currently are to give birth at home or in hospital. We think there's a real opportunity to provide a place where people can have their babies in an appropriate clinic. This is something that I think we're very excited about.

Community health centres: This is another way that we have significantly increased access to care. Community health centres provide care, often to vulnerable populations, to people for whom the social determinants of health are playing a significant negative role in their health. We have doubled the number of CHCs in this province. We are very excited about opportunities in CHCs. They are integrated with other social and health services. In 2003, we had 44 CHCs with 10 satellites; now we have 75 CHCs and 27 satellites. They serve 300,000 people across the province. As I've said often, those CHCs are located in areas where they serve people living in poverty, immigrants to Canada, people facing real barriers to getting the health care that they need. So we're excited about how far we've come with CHCs, and we're also excited about their potential.

Another direction of the government is giving people access to more health care information from sources other than their doctor—not that that information is not important, but we think we can supplement the information that people get. I mentioned our Health Care Options website, a one-stop website where patients can learn more about the health care services in their community. We want health tools, resources and information to be a mouse click or a phone call away for the people of this province.

#### 0940

Our Telehealth phone number has allowed Ontarians to connect with a registered nurse who can answer gen-

eral health questions. They can help assess the symptoms. They can give advice about whether you should stay home and what steps to take, whether you should make an appointment with your family doctor or whether you should go to the emergency department. I think that Telehealth is a service that many families use. Certainly in my own family, it is a service that my daughters with small children use regularly. They want, of course, to do what's best for their child, but they don't want to go to the emergency department if it's not an emergency. Telehealth, I think, is a wonderful service. Last year, Telehealth received nearly 750,000 calls. Ontarians are getting the answers they need and the advice they need.

Diabetes: Diabetes is a complex condition. It is one where management of the disease can make a real difference in the outcomes of the progression of diabetes. We are working very hard to support Ontarians in their efforts to manage diabetes. We've increased the number of diabetes education teams. We had 220; we're now at 321. We've got diabetes regional coordination centres in each of the 14 LHINs. On our website, at [ontario.ca/diabetes](http://ontario.ca/diabetes), patients can find very, very good information on diabetes, how to manage diabetes and what supports there are in their communities.

We've also increased access to cancer screening. We've launched Canada's first province-wide colorectal cancer screening program. We've expanded the Ontario Breast Screening Program to provide an additional 90,000 screens, and we now include women from the ages of 30 to 69 who are at high risk for breast cancer. Those women will get an enhanced screening protocol. We know that the sooner you can catch cancer, the better, so we want to make sure that women who are at high risk of breast cancer get that enhanced screening so that steps can be taken immediately if, in fact, there are any problems that come to light as a result of that screening.

I want to talk about our wait times strategy. As I said earlier, Ontario had unacceptably long wait times, and I know that many people, particularly those who were MPPs and that—well, for me, from 2003 to 2007, but prior to that, we heard very, very sad stories about people who were waiting unacceptably long to get the procedure that they needed. We went to work when we were elected in 2003, and we have gone from not even measuring wait times to now, where we have public reporting on wait times for a range of procedures in every hospital. It's online. People can go and check what the wait time is in their hospital, and where they could go, if they were prepared to travel, to get their procedure done more quickly.

We've invested significantly in our wait times strategy. We've invested \$1.7 billion to reduce those wait times, but I can tell you, the beneficiaries of that are the people of this province, no one benefitting more than our seniors. We have achieved significant wait time reductions. We've taken half a year off wait times for cataracts. We've taken 150 days off wait times for hip replacements. Knee replacement wait times are down 209 days. CT scans are down 48 days. MRI scans are down 37

days. We are making measurable progress. They say if you can't measure it, you can't manage it. We were not measuring wait times. We now measure, and not only do we measure, we publicly report. We have driven those wait times down. When wait times are too high—and there are still some wait times in some parts of the province that are too high—it enables us to make strategic investments to bring those wait times down. We've had difficulty getting MRI wait times down, but we've now been able to target investments to get wait times down where they were too high. We have gone from worst to first on our wait times—and I think three different organizations have acknowledged that Ontario is leading the country when it comes to our wait times. I think that the people of Ontario deserve timely access to care. If you need a new hip, I don't think you should have to spend two years in pain, perhaps not working, in order to get the procedure you need. So I'm very proud of the progress that we've made through our wait times strategy.

Another area where we have moved forward aggressively is in our capital projects. I can tell you that appropriate investments had not been made for too long. We inherited a very serious infrastructure deficit when we took office. We have invested, since we took office, \$9 billion in health care infrastructure. You will know, because I get asked in the House about it, that there are still communities that are anxious and ready for capital improvements to their hospital. We are moving as quickly as we can, but there is still unmet need, and there is no question that it is a result of historic underfunding in capital improvements in our hospitals. We've got 23 new hospitals that have been built or are being built. A hundred major capital projects have been completed or are under construction. We will continue to invest in capital infrastructure.

I now want to turn our attention to our health reality. We've already talked about our fiscal challenge. We do have a deficit that all of us would agree is unacceptably high. We have a plan to get back to balance over the next five years. We can do that, and health will do its part, because we have made significant improvements in health care since we took office. We have seen a substantial increase in health care spending. We now have a very solid foundation, so we can move forward with the fiscal restraints that are part of our responsibility.

I want to pause for a moment on slide 14. For me, this tells a very important and big story. I'm going to take a few minutes just to walk through what you're seeing before you. This is a population pyramid. We have men on the left and women on the right, and each bar represents how many people are in that age cohort currently. The solid bars are from 2010. The red line indicates how many people will be in that age group by 2036. So 25 years ahead, we know, with a very high degree of certainty, what our population age structure will look like. You can see that we will have more people at every age, but we will have not that many people more than we do today at the younger ages. Where we will see huge

growth in the number of people in certain age groups is that older age group. You can see the baby boom moving through the population. You know as well as I do that as we age, we need more from our health care system. Not only are we under significant fiscal constraints, we have a significant demographic challenge.

**0950**

How are we going to achieve those twin fiscal and demographic goals? If you turn to the next page now—

**The Chair (Mr. Michael Prue):** I'm afraid I'm going to have to stop you there because your half-hour is up.

**Hon. Deborah Matthews:** My half-hour is up? Well, I hope I'll have a chance to come back. Thank you.

**The Chair (Mr. Michael Prue):** We now go into the 20-minute rotation periods. Each party will have their opportunity in turn, starting with the Conservatives.

**Mr. Rob Leone:** I'm going to start off where I left off last time. I was wondering if you can measure eHealth Ontario's progress with other jurisdictions. The UK has 99% of their population with electronic health records; we are wondering why Ontario is lagging behind, particularly because we've spent \$2.6 billion on eHealth records that a fraction of that actually have access to. How much is it going to cost to get us all up and running? Why are we lagging behind other jurisdictions?

**Hon. Deborah Matthews:** One important reason why we are lagging behind some jurisdictions—I think it's important to acknowledge that we are leading the way in Canada—is that we did not get started as soon as we should have. Other jurisdictions got started more quickly. Under the previous government there were not investments—there was not a focused success. We are making up for lost time. We are moving forward rapidly—

**Mr. Rob Leone:** But the Auditor General said we started this in the 1990s. The previous government—

**Hon. Deborah Matthews:** Yes, but did not achieve success. Since we were elected, we have really—

**Mr. Rob Leone:** And you've achieved success since you've been elected?

**Hon. Deborah Matthews:** We have now got 60% of our family doctors with EMRs. We're working with the Ontario Medical Association, through their organization OntarioMD, to get more doctors signed up with electronic health records, electronic medical records, in their offices. We support physicians as they adopt and transfer to electronic health records.

There are many physicians who are reluctant to do that. We are working with them, with the OMA, to bring new physicians online. The young doctors, I would say, couldn't imagine practising medicine with paper-based records. We've still got some doctors who are not prepared to transfer their records to electronic, but we're doing everything we can, as aggressively as we can, working with physicians to get them to transfer over.

I'm very optimistic that we will achieve the goal of an EMR for every Ontarian by 2015. We are working with our partners, the Ontario Medical Association, to get there.

**Mr. Rob Leone:** So how much is it going to cost to get a 99% uptake on electronic medical records for people in the province of Ontario? We've spent \$2.5 billion to date on it; we don't have everybody—not even close to everybody—on it. How much more is it going to cost to get everyone on eHealth records?

**Hon. Deborah Matthews:** Because electronic health records, electronic medical records, are such an important part of a strong, sustainable health care system, I think it's important that you actually acknowledge and understand that eHealth Ontario is far more than simply EMRs in family doctors' offices. It's an important part of what they do, but there is much, much more that is being done by eHealth Ontario.

Our hospitals, for example: As the deputy said, if someone goes into the emergency department—a senior or someone on the Ontario Drug Benefit plan—their drug information is available there on the drug profile viewer. All of the scans, CTs, X-rays, ultrasounds, MRIs, all the scans done in hospitals, all the diagnostic imaging in hospitals is digital now, so that can be viewed within the hospital, often within the region. In the case of ENITS, it can be shared with the specialist in another location for immediate care from the right specialist. There is significant work going on.

I can tell you that if we want a highly functioning health care system in Ontario, we must continue to invest in eHealth. There are significant net savings to the system in having electronic health records for people.

**Mr. Rob Leone:** First of all, you've previously stated a cost of \$225 million to hit our target. That was in Hansard on November 4, 2009.

**Hon. Deborah Matthews:** Excuse me, I'm not quite sure what you're referring to.

**Mr. Rob Leone:** I'm talking about Hansard and your previous—

**Hon. Deborah Matthews:** Could you please—

**Mr. Rob Leone:** It says "Hon. Deborah Matthews" on—if you'd like, we could provide that for you. It says here, "The eHealth strategic plan targets a 65% EMR adoption rate by primary care physicians by April 2012.... Achieving the target is thus expected to cost more than \$225 million...." That was stated on November 4, 2009, and we've just discussed earlier today that those projections of eHealth costs have now exceeded \$2.5 billion.

**Hon. Deborah Matthews:** I'd like to go back and check, but I believe that that was the cost of the EMR adoption which is, as I have said, a small but important part of eHealth Ontario.

**Mr. Rob Leone:** I want to ask questions about the drug information system, which is part of the program here. It stated in your eHealth strategy report, 2009, that your procurement was scheduled for October 2010, with a limited rollout pilot planned for April 2011 and full deployment in July 2011. I'm wondering if you could give us an idea of whether we do have full deployment of the drug information system as of July 2011.

**Hon. Deborah Matthews:** It has been delayed. I'm going to ask the deputy to bring us up to date on where we are on the drug information system.

**Mr. Saad Rafi:** Well, eHealth Ontario is in the process of concluding the procurement. Off the top of my head, I don't know whether they have made a selection. I can find out as to the successful vendor. They anticipate that they'll have a medication management system, which is bigger than a drug information system, in place in the next fiscal year. Right now, we're working on an Ontario lab information system, which would have some elements of drug tracking.

**Mr. Rob Leone:** So we don't have a drug information system. Is that correct?

**Mr. Saad Rafi:** We don't have a comprehensive medication management system, which is beyond just a simple tracking of drugs. We do have drug tracking for all ODB recipients, so there is the basis of a drug information system right now. I believe Ontario was the first in the country to have what's called a drug profile viewer in emergency departments.

**Mr. Rob Leone:** Who's delivering that? Is there a company that has been procured to deliver that?

**Mr. Saad Rafi:** I don't know if a company was procured, but I do know that it is now being used and has been adopted through eHealth activities and is used in every hospital. I don't know if there was a vendor, nor who that vendor might have been.

**Hon. Deborah Matthews:** The other important item that we have up and running now is the narcotics database. We now have every prescriber, whether it's a physician or a doctor prescriber; every dispenser, so every pharmacy; and every person for whom that drug is prescribed linked up. This went live just a couple of months ago. We now can make determinations about who is prescribing more than would be considered appropriate, what pharmacies are dispensing at a rate that would raise some questions, and are there people who are getting drugs from more than one physician, going to more than one pharmacy. This is part of our narcotics strategy, to really get the information we need to control these very, very powerful drugs.

**1000**

**Mr. Rob Leone:** We have from your strategy report that 5% of the physicians were supposed to be able to send prescribing events to DIS by October 2011, 65% of community pharmacies were supposed to be submitting dispensing events to DIS by April 2012, and 35% of physicians were supposed to be sending ordering events to DIS by April 2012.

The Ministry of Health and Long-Term Care reports that the fourth-largest cause of death in Ontario is preventable adverse drug reactions and that having an incomplete medication list is the primary source of medical error. eHealth anticipates that the drug information system would save \$350 million annually. Now you're telling me that we're nowhere near having that system operational?

**Mr. Saäd Rafi:** I don't think that's fair to say, that we're not near to having it operational. I think we tried to chronicle some of the elements that are now in place, but linking those systems together in a comprehensive medication management system is under way through procurement, and we hope to have that up and running. It's in the procurement stage, as far as I know.

There's also an ePrescribing pilot taking place where 80,000 Ontarians, with their pharmacist and their physician, have that medication management system as a pilot project. That pilot project will continue until the medication management system is rolling.

**Mr. Rob Leone:** The concern that I have, sir, is that we've spent a lot of money, with some of these things that were supposed to be operational simply not being there, like the DIS. I understand procurement is still in progress.

I'm going to hand it off to Mr. Nicholls.

**Mr. Rick Nicholls:** Thank you very much. You know, Minister, sometimes people think that as the official opposition we have to go after the government in everything. Well, my colleagues and I believe that a good idea doesn't really care who owns it. I'll give you an example of that: family health, a great idea. It truly is. But we also see ourselves as the wallet-watchers of Ontarians, as well. Based on that, I'd like to refer again back to eHealth and some of the things that we have uncovered, because what we're finding is that the eHealth bill has doubled to just over \$2 billion, with very little to show as a result. Of course, the Auditor General pointed that out in his report in 2009, stating that the government had failed to properly oversee the eHealth initiative.

I want to talk about the drug information system again, as my colleague was referencing. For those who may not fully understand what the drug information system is, just a brief definition of it is simply this: a comprehensive record of Ontario's patients' medications, as you've talked about, that would save lives by reducing prescription errors—he talked about over-prescription being the fourth-largest reason for people dying—of course, reducing prescription errors and drug overdoses and reducing fraud related to prescription narcotic addition.

I think that the tools that are in place—obviously we know that they haven't been fully developed yet. Let me ask you this: Who's building the drug information system at this point?

**Hon. Deborah Matthews:** I think what the deputy said was that that is in procurement now, so we don't have an answer for you. We will undertake to get an update on where that process is.

I think it's also important to acknowledge that we have made significant steps. We have a drug profile viewer, so that all seniors, all people on ODSP and OW do have that—it's not a fully fledged drug management system, but those physicians in emergency departments can see what drugs that person is on.

You talked about reducing fraud for narcotics. We have that in place now and that is operational now. We have made significant steps forward. We keep hearing

about the Auditor General's report. I think it's important to remind you that \$800 million of the total \$1 billion went to the ill-fated Smart Systems agencies that the Liberals inherited from the Tories, the auditor noted in his report.

We are moving forward. We are making up for lost time. We believe this is the right thing to do, and we are making the appropriate investments to get there. This work is under way. It's difficult work, but it is work that is vitally important for the people of this province. We've remained committed to the objectives that have been outlined by eHealth Ontario.

**Mr. Rick Nicholls:** We do know that you have spent over a billion dollars while—

**Hon. Deborah Matthews:** With significant results—60% of family docs; we're on our way to improve that over the next few years. By 2015, we want an EMR for every Ontarian. We are working towards that goal. There is no light switch you can just turn on to make that happen. Every physician who signs up goes through a significant change in their office. We are working with our doctors to continually improve and increase the number of docs who have EMRs and who are using it to its full power, because EMRs have tremendous power and not all of the physicians who are hooked up are using the full scope of electronic medical records.

I'm excited about the future of eHealth. We are making the right investments. Those investments will pay great dividends and are paying great dividends.

**Mr. Rick Nicholls:** Back to the drug information system, though, and who is building it—and perhaps it hasn't been procured yet. But we do have it on good authority that Telus Health Solutions is poised to be awarded two major eHealth contracts: the drug information system and the ConnectingGTA initiative. These two contracts will amount to roughly \$70 million.

We've also been told by whistle-blowers at eHealth, who are disgusted with your management, that two other firms, namely IBM and Accenture, walked away from the DIS project due to a number of concerns. Can you please elaborate on the situation? Why did IBM and Accenture walk away?

**Hon. Deborah Matthews:** I cannot confirm nor comment on those allegations. I don't know if the deputy has anything to add to that.

**Mr. Saäd Rafi:** I don't know the procurement details that you're referring to—

**Mr. Rick Nicholls:** So you're not aware that Telus Health Solutions may in fact be poised to be awarded those two contracts?

**Mr. Saäd Rafi:** I wouldn't be, nor would the minister, in terms of delving into a procurement process or influencing or accessing information during a procurement process.

**Hon. Deborah Matthews:** I would never get involved in a procurement process—never.

**Mr. Rick Nicholls:** I think that IBM and Accenture are walking away because of the risk factor involved. That may be very fair to say.

Are you aware, Minister, of who's running Telus Health Solutions?

**Hon. Deborah Matthews:** Perhaps I should, but I'm not sure that I do.

**Mr. Rick Nicholls:** Well, perhaps I could help you with that. Telus absorbed Courtyard Group and two senior executives, Michael Guerriere and David Wattling, two central figures in the eHealth scandal. My question is, do you think it's appropriate for two of the architects of the last eHealth scandal to be awarded major health contracts?

**Hon. Deborah Matthews:** If you are suggesting that there be political interference in the procurement process, I completely, unequivocally reject that advice. If you are giving me advice that certain individuals—

**Mr. Rick Nicholls:** I'm not giving you advice. I'm just—

**Hon. Deborah Matthews:** Well, you are suggesting that there be political interference in a procurement process. I reject that. It is an irresponsible approach.

**Mr. Rick Nicholls:** We're just asking, Minister, if it would be correct and the right thing to do. You see, cronyism and scandalous overspending are still commonplace at eHealth, aren't they?

Will you table for this committee the expenses of all eHealth employees, particularly the management executive and board?

**Hon. Deborah Matthews:** I believe there was a motion that this committee passed last week that requested that information, and we will endeavour to get that information for you.

I need to, however—

**Mr. Rick Nicholls:** Just yes or no.

1010

**Hon. Deborah Matthews:** Excuse me. You've made some very serious allegations, some very serious allegations. What I will do—

**Mr. Rick Nicholls:** Yes, ma'am, I have, but this is very serious too, and I know you know that.

**Hon. Deborah Matthews:** We will endeavour to reply to the committee's request to get that information.

**Mr. Rick Nicholls:** Thank you. I appreciate that.

**The Chair (Mr. Michael Prue):** We have about one minute.

**Mr. Rick Nicholls:** Okay. The Auditor General's report states that the DIS, the drug information system, was supposed to be completed over four years and implemented by 2013. It's 2012, and the vendor hasn't been determined. What's the reasoning for that?

**Hon. Deborah Matthews:** I will turn to my deputy for any information he might have on that.

**Mr. Saäd Rafi:** I would have to get those details from eHealth Ontario, but I think some of the elements in large system development would be known to you. I don't need to repeat those. A pilot program was started, as well as an approach that has been implemented through sub-systems that track drug information.

**Mr. Rick Nicholls:** I was just hoping, though, sir, that you would be able to track all of that and be aware—

**The Chair (Mr. Michael Prue):** I have to stop you both there because the time is up.

**Mr. Rick Nicholls:** That's what I'm asking.

**The Chair (Mr. Michael Prue):** Think about it for the next time. The time is up.

We're going to go to Ms. Gélinas, and after that, I'm going to suggest that we take a 10-minute recess for the benefit of all concerned. Ms. Gélinas, you have 20 minutes, and then we're going to have a recess.

**M<sup>me</sup> France Gélinas:** Sounds good. I wanted to ask a few questions about oral health, the first one having to do with CINOT, children in need of treatment. I was wondering, what was the budget allocation specifically for CINOT in 2011-12, and how much was actually spent? If we have this available today, that would be great.

**Hon. Deborah Matthews:** I'll just give the deputy a moment to see if he's got it here. Otherwise, we will endeavour to get it for you.

**Mr. Saäd Rafi:** I'll have to get that information. I don't readily have the CINOT data.

**M<sup>me</sup> France Gélinas:** If it comes as we talk, feel free to throw it in at any time. I would be interested in knowing what was budgeted in 2011-12, what was actually spent in 2011-12, and what is budgeted for this year, in 2012-13, and if you would know if it went up, down or stayed the same. Is there hope that you find it right away, or should I just be patient and we'll get it within 30 days or—

**Mr. Saäd Rafi:** Between those two, I will definitely have it.

**M<sup>me</sup> France Gélinas:** Okay; sounds good.

A similar question regarding the Healthy Smiles Ontario program: What was budgeted in 2011-12, how much did we actually spend in 2011-12, what are the budget allocations for 2012-13, and why is it so hard to find those numbers in that big book? You don't have to answer that last question, but it's really tough to find those numbers. If they would be more easily available, it would save us all some grief.

**Mr. Saäd Rafi:** Okay. I will take you on your advice not to answer the latter, but it is a function of the quantum of programs and the various vote item lines, as you would well know, that these funds are found; so, in the printed estimates, it is aggregated at such a level that it may not be obvious to find specific, individual-type programs like CINOT, Healthy Smiles or Aging at Home, for example, just another piece.

**Hon. Deborah Matthews:** But what I do want to comment on in Healthy Smiles is that this is a program that was part of our poverty reduction strategy. As you know, kids whose parents are on social assistance have access to dental care, but kids whose parents were working, but not making a lot of money, did not have access. It's for many families who are struggling to pay the rent and pay the bills and buy food. Dental care just was not able to be provided to those kids.

Healthy Smiles is a new program delivered by our public health units that is for the first time providing den-

tal care at no cost to kids in low-income families. I'm enormously proud that we've made this investment.

**M<sup>me</sup> France Gélinas:** Sounds good. Continuing in the community sector, in 2011-12, the Ministry of Health budget for the community sector received a 3% increase, and this increase was allocated to the LHINs. I was just curious to find out: Of the 3% increase that went to the community sector, how much went to the community care access centres? How much of the total amount of that 3% ended up with CCACs versus, I would say, everybody else in the community sector, and more specifically, community health centres in the community sector?

**Mr. Saäd Rafi:** Just to clarify: You're looking for the breakdown of the 3% from CCACs versus CHCs?

**M<sup>me</sup> France Gélinas:** There was a 3% increase in community care. The 3% did get rolled out. I'm interested in seeing the breakdown as to—I used to know the amount; it escapes me. To make it easy, let's just say that the 3% meant that there was a \$100-million increase. Of that \$100 million, how much went to CCACs and how much went to other parts—in numbers as well as in percentages. I would appreciate knowing.

**Mr. Saäd Rafi:** We'll have to get that.

**M<sup>me</sup> France Gélinas:** Okay, that would be good.

**Hon. Deborah Matthews:** What I would like to add, though, is that we made a strategic decision to increase the community sector by 4%—

**M<sup>me</sup> France Gélinas:** This year.

**Hon. Deborah Matthews:**—this year and the next two years, while we're holding physician compensation at zero, while we're holding hospital base increases at zero. We've made a very clear strategic decision to invest more in the community sector, because we know that a greater investment in home care—not just home care, but in-home care—can bring some of those ALC patients out of hospitals.

You're from the Sudbury area. You know that there are too many people who could go home or could go to another place outside of hospital to receive the care they need but who are in hospital.

We have been very clear with the LHINs that this increased investment is not just an increase across the board to everybody in that sector. They need to be very strategic in using this increase in money to drive the kind of change we need to rebalance the health care system, to increase spending in the community as we hold others flat.

**M<sup>me</sup> France Gélinas:** It's a little bit fuzzy as to who is in the community care sector and who is out. For the 4% that will be rolling out for the next three years, who can the LHINs envision using that 4%? Who's in, who's out?

**Hon. Deborah Matthews:** It is community-based services: community-based mental health; supportive housing; home care. We could get you the list of what's in there. It's not hospital, not physician, not drug; it's community-based services. The whole idea is, let's get people the care they need, as close to home as possible, out of institutions whenever possible.

**M<sup>me</sup> France Gélinas:** I would be able to get a list of who those transfer payment agencies could be, as in who is in the community sector and who is not?

**Hon. Deborah Matthews:** What's captured in that line.

**Mr. Saäd Rafi:** I think the transfer payment agencies would be several hundred, so it would be advantageous for us if it was about who's captured in that line of funding. Long-term care is not, for example. It's strictly that community basis. We would be able to tell you, "The 4% is going to flow to these types of community transfer payment partners."

**M<sup>me</sup> France Gélinas:** That would be acceptable.

**Hon. Deborah Matthews:** If you'd turn to page 16 on the slide deck, that is a breakdown of where we spend health care dollars: what sectors receive what share of the health care pie. You will see that that community sector represents, I think, 6.2% of the budget. We're really focusing on that sector, because we think that the appropriate investments there will take pressure off other parts of our health care system.

1020

**M<sup>me</sup> France Gélinas:** Then I would be interested in seeing who makes up that 6.2%.

**Mr. Saäd Rafi:** Sure.

**M<sup>me</sup> France Gélinas:** Okay.

**Hon. Deborah Matthews:** Yes, and each of the LHINs will have information on their websites that describe their investments, as well.

**Mr. Saäd Rafi:** I might add on that last point, if I could, that the allocation will vary by LHIN because of local need.

**M<sup>me</sup> France Gélinas:** I understand. Talking a little bit about hospitals, we've made it clear, zero percent overall in the hospital envelope with—

**Hon. Deborah Matthews:** No, zero percent on the base, but we are increasing investments on the wait times strategy, cancer care, where populations are growing, if there is a growth in services—but the base is zero.

**M<sup>me</sup> France Gélinas:** Can you provide a breakdown in amounts, by hospital in each of the LHINs, for all 152 hospital corporations, of base funding for each and every one of them, as well as additional funding for those particular hospitals? So whether it be additional funding for post-construction or for high growth or for wait times—

**Hon. Deborah Matthews:** So the one-time funding?

**M<sup>me</sup> France Gélinas:** Not necessarily one-time; I want the operating as well as any additional funding that goes to those different hospitals, that comes from the ministry and ends up there.

**Hon. Deborah Matthews:** Yes.

**M<sup>me</sup> France Gélinas:** It's feasible? Okay, that would be very helpful. Thank you.

Do we know—I call it other sources of funding, like the nurses for offload delays. We had the offload nursing positions. Can we find out exactly where they went?

**Mr. Saäd Rafi:** Yes.

**M<sup>me</sup> France Gélinas:** That would be helpful too; even a chart with—I'm interested by names of hospitals, as to

which hospital got one and which didn't and if they got more than one; basically a breakdown as to where they went.

**Mr. Saäd Rafi:** Okay.

**M<sup>me</sup> France Gélinas:** Okay; sounds good.

The LHINs have been doing some consolidation; that's the way they call it in my LHIN, anyway, but I think it's pretty standard. They've been consolidating programs and services. Sometimes it's a program or service that was within the hospital, sometimes it's in the community, and sometimes it's both of them together. Do we have a list of where this has happened province-wide? What kind of consolidation of services and programs have happened, but specifically touching hospitals? Have all of them—the big, the small, the rural, the northern—been basically consolidated the same?

**Mr. Saäd Rafi:** As an accounting consolidation, in that context? Absolutely.

**M<sup>me</sup> France Gélinas:** No, as programs and services. The LHINs have made integration decisions that often touch hospital programs and services, and I'm curious to know, did we keep track of those on a hospital basis? How many of those integration decisions have touched the 152 hospitals, specifically their programs and services?

**Mr. Saäd Rafi:** Do you have an example of an integration decision? That's sort of throwing me off in the sense of the LHINs' role with respect to integration.

**M<sup>me</sup> France Gélinas:** I'm trying to use their language. I never call it integration decisions; I call it consolidation of programs and services. There used to be physiotherapy offered in a specific community hospital. The LHINs looked at it and found out that the community was well served in physiotherapy services, so they basically—when the hospital came forward, they called it an integration decision. But call it consolidation, call it whatever, it's basically a program and service that used to be offered in our hospital that is not offered in our hospital anymore because they were being well served by the community side of the equation. I'm curious to see how many of those—I will call them consolidations of programs and services. Are you starting to see where I'm going?

**Mr. Saäd Rafi:** Yes.

**M<sup>me</sup> France Gélinas:** How many of those have happened in our hospitals, let's say, for the last—2011-12, or if you know 2012-13 going forward. Those are programs and services that used to be offered in the hospital. They either are not or they're offered in a different way or they're offered in a partnership. So when the LHINs have made those decisions, where have they been done?

**Mr. Saäd Rafi:** That one I'm going to have to have a concerted chat with staff about. I don't know the answer, and we'll have to determine how we can compile that information.

**Hon. Deborah Matthews:** I think it's important to acknowledge that this is the work of the LHINs.

**M<sup>me</sup> France Gélinas:** Yes, it is.

**Hon. Deborah Matthews:** Each LHIN is entrusted with the responsibility of getting best value, best care for patients. The LHINs will have that information. We will see what we can get. Again, I think that you might get more robust information if you work directly with the LHINs. We'll get you what we can, but I have a feeling you're going to want information that probably the LHINs are best equipped to share with you.

**M<sup>me</sup> France Gélinas:** If that information is shared with the ministry, if that kind of planning is shared with the ministry and you have that information, then I would like it. If you don't, then I have the numbers of the 14 LHINs and I can do the phone calls.

Another thing that I was wondering—I know that the LHINs know this, but I'm wondering if they report back to you in your stewardship capacity—is the number of hospital beds that are in operation. Do you keep track of this? Do the LHINs or the hospitals themselves let you know the number of beds in operation at any given time—the example that you gave earlier on, that sometimes in the summer they will close a wing, 25 beds in med surgery or whatever. Do they inform you? Do we keep track? Do we know?

**Hon. Deborah Matthews:** We know how many hospital beds are operational. There could be some occasions when there's a temporary change. We do track the number of beds that are being operated in our hospitals and our long-term-care homes, our acute-care hospitals, our complex continuing care hospitals, our assess-and-restore beds. There are a range of different kinds of beds, and we do keep numbers on each type of bed that's open.

**M<sup>me</sup> France Gélinas:** That would be helpful. I would like it by each type of bed, the different clinical areas: How many hospital beds do we have for peds or for ob-gyn or—

**Hon. Deborah Matthews:** Now you're getting into—I'm not sure we have that. We'll see what we can—

**M<sup>me</sup> France Gélinas:** You would just have acute-care or complex continuing care? Or do you have it drilled down to clinical areas?

**Mr. Saäd Rafi:** I don't know how far it drills down. It would also be at a point in time, because daily and monthly operation decisions are being—

**M<sup>me</sup> France Gélinas:** Pick a point in time, and I'll be happy with whatever you pick as long as it's not 10 years old. Within the last—2011-12—just to give us a baseline as to how many. If you trend them, then I would also be interested in knowing where things are changing.

**Hon. Deborah Matthews:** There's no question that procedures that used to keep people in the hospital for a week are now being done as day surgery. So health care is changing and that's good.

**M<sup>me</sup> France Gélinas:** Absolutely.

Actually, if I had my druthers, I would ask for July 1, 2012, but I will take whatever date you can give me that is as close to July 1, 2012, as possible.

**Hon. Deborah Matthews:** What about July 23?

**M<sup>me</sup> France Gélinas:** I'm also looking for the hospital operating funding for 2012-13, as well as 2011-12

and 2010-11—strictly the operating funding that went to our hospitals. You can give this to me either breaking down by LHINs—or even if it's one big number, I'll live with that, too. I would prefer it by LHIN.

**Mr. Saäd Rafi:** By LHIN or by hospital?

**M<sup>me</sup> France Gélinas:** Oh, if you have it broken down by hospital, it's even better.

**Mr. Saäd Rafi:** I would imagine you would prefer it by hospital. I think we can provide it by hospital for the 2012-13 budgetary allocation and, I believe, for 2010-11 and 2011-12 as well.

**M<sup>me</sup> France Gélinas:** When we look at it—what I'm able to get from that little book that's hard to read—it looks like the operating funding of the hospital, the line that is used, keeps going up, but I'm not too sure what accounts for the growth. Do you know?

**Mr. Saäd Rafi:** Generally, there would be a line of strict growth on the base. Last year it was 1.5%, I believe; this year it's frozen at 0%. Then there are additional funds that come to individual hospitals. That might be PCOP, the post-construction operating that you've identified. It would definitely be any provincial program money that would be for special types of activities that might be unique in a particular series of hospitals but not apply to all hospitals, and then, of course, surgical wait-time monies that are allocated. Lastly, another amount would be the cancer surgery allocations that come out of Cancer Care Ontario. They look at the volumes and the types of surgeries for cancer. Some of that is wait-time; some of it is not.

**M<sup>me</sup> France Gélinas:** How long do I have, Mr. Chair?

**The Chair (Mr. Michael Prue):** Very little. Twenty seconds.

**M<sup>me</sup> France Gélinas:** Do we know if public health will be integrated into the LHINs, and if so, when?

**Hon. Deborah Matthews:** That's not part of our action plan right now. We are looking to integrate primary care planning. There are certainly people who advocate that public health should be there, but they are, as you know, creatures of the municipalities. What I think is very important, though, is that the LHINs and public health are working together to achieve best possible outcomes for best possible value.

**M<sup>me</sup> France Gélinas:** So no—

**The Chair (Mr. Michael Prue):** We're going to stop you right there.

Mr. McNeely.

**Mr. Phil McNeely:** Thank you, Chair, and thank you, Minister, for being here.

**The Chair (Mr. Michael Prue):** No, we were going to have a break.

**Mr. Phil McNeely:** Oh, great.

**The Chair (Mr. Michael Prue):** I thought you had a point of order or something you wanted to—

**Mr. Phil McNeely:** No, no. I was suggesting a break. I didn't realize that. Great.

**The Chair (Mr. Michael Prue):** We are going to break for 10 minutes. Please, everybody be promptly back here at 20 minutes to.

*The committee recessed from 1032 to 1044.*

**The Chair (Mr. Michael Prue):** We'll call everybody to order, and we will start. It is now the opportunity of the government. Mr. McNeely, I understand you have the first question.

**Mr. Phil McNeely:** Thank you, Chair. I was very interested in your presentation, Minister, when you were coming to the demographic challenges. I can see that persons my age are going to about double by 2036, and the ones who are paying the bills are only going to go up 15% or something. I would like you to complete your presentation, and I'd like to see the rest of the information that you have provided this morning.

**Hon. Deborah Matthews:** Thank you very much, Mr. McNeely. I do think that this demographic challenge really does underlie every decision that we have to make in health care. We want to provide the best possible care for people today, but we always have to be looking ahead to see what's coming. What does the future look like? What is our health care system going to need? How is our health care system going to need to change, to reflect the needs of the people of the population at the time?

When we embarked on universal health care 50 years ago, our population was much, much younger, and the demands on the health care system tended to be more episodic. You had something wrong with you; you went in and you got it fixed, and then you were healthy again.

As our population ages, the very nature of our health care system has to change to reflect that. As people age, and as health care improves, people are living longer, and they're living longer with more complex conditions, and our health care system to date has not adapted to reflect the changing needs of our population.

This slide on page 14 is pretty sobering, for exactly the reason you pointed out. The needs of people in their 70s, in their 80s, in their 90s—and just look at the number of people who are going to be over 100 years old—an extraordinary increase in people who will have demands of our health care system that we simply aren't poised to meet right now.

If you look just at the money, the next slide demonstrates what would happen if we took the per capita spend by age of today and then multiplied it by the population structure of 2030, just 20 years from now. You'll see the blue line represents what we spend by age group today. The green line is what we will spend by age group 20 years from now if we continue to do everything the way we do it today. The answer is, we would need an increase in our budget of 50%. That's not accounting for inflation; that's not accounting for new medical advancements. It's just, if we had the population of 2030 to care for today, how much more money would we need? It would be an increase of 50%. This is a very sober reminder that we need to make sure that we're getting the best value for every tax dollar.

We know that we can do so much better for people as they age. We have seniors who have a number of different doctors that they see for different parts of their body that need attention. That care is not nearly as coordinated

as it could be. We know that we could be a lot more proactive when it comes to health care.

We asked Dr. David Walker from Queen's University to help us understand what we needed to do to address the ER/ALC challenges. He came back and said, "I can help you with that, but I need to broaden the scope."

The problem is, we're not taking as good care as we should, and could, of our seniors. That's why we're moving forward with the seniors strategy. We want to support more people in their home, keep them out of hospital, get them out of hospital as soon as they're ready to go home. We want them to go home with the most robust supports: what they need to stay healthy, prevent hospital readmissions, make sure that they're on the right medications and they're taking those medications properly.

We know that if we took a more holistic, integrated approach to health care for our seniors, we could provide much better care at a lower cost. That's why we are really driving change that not everyone is happy with.

#### 1050

Many physicians aren't happy that we're not increasing the envelope for physician compensation. Some of our hospitals would like to see a higher increase in their budgets. But I tell you, if we're going to drive the change that will keep our health care system universal for future generations, we have to do a better job of caring for elderly people. It's as simple as that.

On slide 16, this is where we spend money in health care: 34.5 % in our hospitals—more than a third of our health care dollars go to hospitals—doctors, 23%; long-term-care homes, 8%; community care, 6.2%. That "Other" category includes things like public health and mental health. This is how much money we have to spend. That pie will grow a little bit, but it will grow less than we have been used to seeing. Where do we have to shift spending within this pie to get the best outcomes for people? That is what our action plan is all about.

We know we can get better value for the money we spend. If you talk to anyone who works on the front lines of health care, they will all tell you that there are ways where we can spend money more effectively for better patient care. We need to listen to people on the front lines. We need to respond to the issues that they raise and make the changes that will be uncomfortable for some, but we need to drive change.

If we value universal health care, if we want to be able to pass on what I consider to be the greatest gift that people in public life gave us, universal health care, if we want to pass that on to the next generation, we must drive change. We have no option.

That's why we introduced the action plan. You've heard the three pillars: keeping Ontario healthy by focusing more on prevention, a stronger role for family health care, and ensuring that Ontarians get access when they need it to their primary health care provider. We have to make sure that people are getting the right care—that is, care that is evidence-based—at the right time—and that is very often earlier than they're getting it now, particularly when it comes to mental health—in the right

place—that's all about, if you don't need to be in hospital, we don't want you in hospital. We want to give you the support you need to move out of hospital and get back home where you're the most comfortable and where you'll make the greatest recovery. We know that when people spend too long in hospital, their condition actually declines at a fairly rapid rate. So we need to get people back home, participating in their home, in their family, in their community. Making those investments to get people home is the right thing to do for our seniors. That basically is where we're going.

Another piece of our action plan that I'd just like to touch on is the notion that there are procedures that are done in hospitals now that don't need to be done in hospitals. They could be done outside of hospitals in a stand-alone clinic. So we are looking at options. They need to be not-for-profit clinics because that's where we'll get the best value. It will provide faster access. It will provide higher quality or as-high quality, and we'll get better value for that money.

I had the opportunity to visit the Kensington Eye Institute, where all they do is cataract surgery and specialized eye care. Because they've got one focus and one focus only, they're able to provide that care in a way that works very, very well for patients.

Our goal is to make Ontario the healthiest place in North America to grow up and grow old. There's no reason we can't achieve that goal. We have everything we need here in Ontario. We've got brilliant, dedicated health care professionals. Our doctors are second to none. Our nurses, our various health care providers are superb. We need to let them do their job. We have everything we need to make Ontario the healthiest place to grow up and grow old, and we're going to get there by driving better value for our health care dollars and focusing on quality.

So that's our big-picture challenge and every year, every day, we want to move closer to that goal of having the system balanced, where the investments are in the right place.

**Mr. Phil McNeely:** Thank you, Minister. I just know how many wonderful things our hospitals, our doctors and our health professionals do. We had the story this past weekend of the young lady from Ottawa who had the double lung transplant, and that was just marvellous, what happened here in Toronto.

**Hon. Deborah Matthews:** An inspiration.

**Mr. Phil McNeely:** Chair, I have some questions that I would like to direct to the Chief Medical Officer of Health, Dr. Arlene King, if we can go there now. If she could come up to the table, please.

**Mr. Saïd Rafi:** We will see if we can get her—

**Hon. Deborah Matthews:** Oh, she's here? There she is.

*Interjections.*

**The Chair (Mr. Michael Prue):** Dr. King, for the purposes of Hansard, if you could just state your name so they have the right—

**Dr. Arlene King:** My name is Dr. Arlene King, and I'm the Chief Medical Officer of Health for Ontario.

**The Chair (Mr. Michael Prue):** Mr. McNeely, the floor is yours.

**Mr. Phil McNeely:** Thank you, Dr. King, for being here. My first question is that anti-vaccine sentiments seem to exist in Ontario and across the world. What can you tell us about the importance of immunization and publicly funded vaccines in Ontario?

**Dr. Arlene King:** Immunization is probably the most effective and cost-effective health intervention that we've invested in over the last 100 years. Ontario has continued to invest in introducing new vaccines to protect the health of the population. Specifically, last summer we actually introduced a couple of new vaccines to protect the health of infants and young children and also expanded the use of other vaccines to adults as well.

I certainly am aware and acknowledge the fact that there are in some areas increased concerns about the safety of our vaccines, but they have certainly been proven to be among the most effective and safest of our health interventions in terms of protecting the health of the population.

**Mr. Phil McNeely:** We still have a couple of months of summer left, but I imagine that you're working hard to ensure that Ontarians are protected from the flu. What can you tell us about this year's upcoming flu program?

**Dr. Arlene King:** Again, we never know and can never predict exactly what our flu season is going to look like. I don't have a crystal ball, but we know it's going to come, so we do a lot of work, year-round actually, to continue to improve our publicly funded influenza program. Of course, we're in the process of preparing to deliver our Universal Influenza Immunization Program again in the fall, with constant attention to how we can improve our uptake rates in all parts of our population—an important intervention in terms of saving lives and reducing the burden on the health system as well.

**Mr. Phil McNeely:** To change to another subject, there are a number of communities in Ontario that have been debating the issue of fluoride in drinking water, Orillia being the most recent. Can you explain why this is such an important issue from a public health perspective?

**Dr. Arlene King:** Again, oral health is extremely important. You're probably all aware of that. From my perspective it's key, because I just issued a report on oral health in Ontario. Fluoridation specifically is one component of a comprehensive, population-based oral health program that really is an equitable factor. It reaches every Ontarian. It enables the protection of teeth not only just in young children but, again, reaches adults as well. With growing concerns related to root cavities, particularly in elderly people, reaching all segments of the population is really important. That, in conjunction of course with the individual one-on-one preventive interventions that we offer through programs like Healthy Smiles Ontario, for instance, and CINOT, is a really important package in terms of optimizing the oral health of Ontarians.

It's not just about teeth; it's a lot more than cavities, to quote the title of my report. It's also a good way to ensure that we improve our overall health status. It's harder to

eat when your teeth aren't good. It's particularly hard to eat when you've got—trying to eat fruits and vegetables, either as children or as older adults. That's why oral health is important and fluoridation is important. It's a tried and true method of trying to promote the oral health of the population in an equitable fashion.

1100

**Mr. Phil McNeely:** Have you been dealing with—I'm sorry? Minister.

**Hon. Deborah Matthews:** I'd just like to add on the fluoridation—and excuse me if I'm interrupting you, but I think it's really important that people think about who is most negatively impacted by the removal of fluoridation from water.

We know that fluoridation is naturally occurring in some parts of Ontario. In other parts, a very small amount of fluoride is added. The people who benefit the most from that added fluoridation are kids in low-income families, kids who cannot access the dental care that kids who grow up in families with dental programs are able to access. This is an issue that impacts all of us, but the most heavily impacted are the people with the lowest incomes. I just think it's important in this fluoride debate that we introduce the concept that those least able to afford dental care are the most seriously impacted.

I have a little bit of a vested interest. My grandfather Jack Matthews was mayor of Brantford, the first city in Canada to introduce fluoride. That was a decision he made as mayor. It's an issue that I follow closely, but I really do think that if we can prevent kids from getting cavities in a very, very safe way, then we should do that.

**Mr. Phil McNeely:** To go back to the medical officer of health, how are you working with the municipalities to make sure that the right information, the right feedback from the municipalities is being used?

**Dr. Arlene King:** This is a really important question, because I think it's a good example of how we in the centre are collaborating closely with the local health units to ensure that people get the right information. I'm aware of the fact that there is a lot of misinformation out there that I think is potentially a source of confusion for local decision-makers. That's why, first of all, prior to issuing my report, we've been working very, very closely with Health Canada on ensuring that the health units have all of the questions and answers that are evidence-based in response to the questions that they've received. Subsequent to that, I did my Oral Health report to ensure that there was a good understanding of oral health and the contribution of fluoridation to that activity.

I've had the privilege of going out to many municipal governments throughout the province of Ontario to lend support to my colleagues as they are making arguments in support of maintaining fluoridation or, alternatively, writing letters to provide the support that is needed to ensure that, again, decision-makers have all of the information that they need.

**Mr. Phil McNeely:** Fluorosis has been raised as an issue. I hear that this can be one of the side effects of too much fluoride. What are your comments there?

**Dr. Arlene King:** Certainly, fluorosis is a recognized side effect of having too much fluoride. That being said, there was a study done in Canada in 2007, and the amount of fluorosis is, first of all, on the decline, and secondly, it was so negligible, they were not able to report on it in terms of severe fluorosis.

Most fluorosis that occurs, either mild or moderate—it really is just a matter of discolouration. It doesn't actually affect the functioning of the teeth. But in terms of anything severe, even moderate or severe, there wasn't enough fluorosis in the country identified that they could even count it on the Canadian Community Health Survey abstracts.

**Mr. Phil McNeely:** So why is oral health so important, then, to you as a public health official?

**Dr. Arlene King:** Well, I think it's really unrecognized. I think that, by and large, the mouth is largely disconnected from the rest of the human body, so I felt it was important to comment on the fact that the mouth is an important contributor to our overall health, to the prevention of chronic diseases and to our overall well-being.

The WHO has certainly cited this evidence-based information that oral health is really important to our overall well-being as individuals and our overall health status. I wanted to ensure that Ontarians had that understanding.

**The Chair (Mr. Michael Prue):** I'm going to have to stop you there. The Conservatives now have 20 minutes.

**Mr. Rick Nicholls:** Doctor, interesting statistics with regard to immunization, something that perhaps we could have an interesting discussion on a little bit later on. However, I would again like to direct my question to the minister.

Minister, we're back on the drug information system. This should have been procured by 2009. You're three years late. And again, I guess my question is, what happened? Who is being held accountable for being three years late?

**Hon. Deborah Matthews:** A few things I think you would be interested in knowing: The procurement is through Infrastructure Ontario, so they are responsible for the procurement for eHealth Ontario. They are concluding the procurement process for the drug information system. The next phase is the negotiation of a contract, which typically takes two to three months. The design-and-build phase follows the signing of the contract.

We are on track for limited release by about June 2013, and we'll ramp up from there. "Limited release" means tools like ePrescribing will be used by a collection of physicians and pharmacies. We'll ramp up from there, very much like electronic medical records, ramping up uptake.

The drug profile viewer, which we've talked about, is operational in 245 hospital sites. I think it's important to acknowledge that that part of the drug system is operational—20 community health centres. It provides prescription drug information and medication histories for 2.6 million Ontario Drug Benefit recipients. It's oper-

ational 24 hours a day, seven days a week. That work is operational.

We've got 80,000 patients who are part of a pilot now in the electronic prescribing initiative. It's at the Georgian Bay Family Health Team, the group health centre, and they are demonstrating the advantages of a medication management system.

We are under way with the procurement, and we are looking forward to the release of this.

**Mr. Rick Nicholls:** Thank you. Here are the facts, Minister, as we know them. DIS was supposed to undergo a limited rollout in April 2011. At that time, you hadn't even announced the pre-qualified bidders.

**Mr. Rob Leone:** Point of order, Chair.

**The Chair (Mr. Michael Prue):** Point of order.

**Mr. Rob Leone:** Sorry, Mr. Nicholls. I was wondering: We don't have Dr. King on the ministerial staff list that was provided on the agenda, but there are some questions that we would like to ask, if she's still available to continue sitting at this committee. Is there any provision that we could request her presence here?

**The Chair (Mr. Michael Prue):** If you're doing that now, I would ask that she be made available. She's not on the list, and that's correct; I was surprised to see her here. But since she has already given opinion, I think all sides are entitled to hear from her if they choose to do so. Would you like her in this round, or would you like her later, or—

**Mr. Rob Leone:** We have some questions this round as well.

**The Chair (Mr. Michael Prue):** Okay. Dr. King, I would ask, since you have arrived, that you stay for the balance, until it's indicated that you are not required any longer.

**Dr. Arlene King:** Okay.

**The Chair (Mr. Michael Prue):** Thank you.

**Mr. Rob Leone:** Thank you, Mr. Chair.

**Mr. Rick Nicholls:** Again, let me just reiterate my previous statement, Minister. DIS was supposed to undergo a limited rollout pilot in April 2011. At that time, you hadn't even announced the pre-qualified bidders.

Then, the DIS should have been actually fully deployed by July 2011; that's a year ago. Again, at that time—the bidders were only announced on July 5 of last year.

By October of last year, only 5% of physicians were supposed to be sending prescribing events to the DIS. Right now, 0% are doing so.

By April of this year, 65% of community pharmacies were supposed to be submitting dispensing events to the DIS. Well, that number is 0% at this point in time. And then by April 2012, 35% of physicians were to be sending ordering events to the DIS, and again, currently 0% are capable of doing so.

**1110**

Minister, this isn't a disaster; eHealth is a complete and utter joke at this time. What do you have to say for yourself and for the ministry and the state of current events?

**Hon. Deborah Matthews:** eHealth is a vital, essential, necessary component of having a sustainable health care system for the future of Ontario. I cannot stress enough how important it is that we move forward in a responsible way to implement each of the elements that will get us to where we need to get to.

**Mr. Rick Nicholls:** The only thing that's growing, Minister, is the cost to taxpayers, with zero benefit at this point in time. With the scheduling—and you set the schedules—we're behind the times quite significantly. Again, when we talk about the all-encompassing eHealth, we're looking at over \$2 billion. But we're talking about the drug information system at this point.

**Hon. Deborah Matthews:** I have to disagree with your suggestion that any taxpayer dollars have been—I forget the word you used—spent on this. Is it late? Yes, it is late. Nobody is suggesting otherwise. Is it essential that it move forward? Yes. Have we got elements of it up and running? Yes.

I would be more than happy to get you specific answers from eHealth Ontario, from Greg Reed, who I'm sure could offer more detailed information. But what I can tell you is that elements of this are operational.

We have the narcotics database up and running today. We are collecting information on who is prescribing, who is dispensing and who is receiving opioids in the province of Ontario. We needed to do that because we knew that there were too many people in this province who were visiting multiple doctors to get prescriptions for opioids, that there were some pharmacies that were dispensing without asking the right questions, that certain patients were getting access to prescription narcotics that were not being used for the intended purposes. That part is fully operational now. In fact, I was very pleased to see an article in Ottawa that the number of pharmacies that are being broken into has been reduced, I think, to zero, of late. So we are making improvements. We are moving forward.

We're looking forward to the drug information system being fully operational, and we're on track to see that in 2013. I do think that you would agree that getting it right is more important than getting it done on time. I will not support moving forward until we are ready to move forward. If we know we can do better, then I'm prepared to take the time to make it right. This is a very important issue.

**Mr. Rick Nicholls:** My closing comment, Minister—then I'm going to turn it over to my colleague—is that surely your ministry must be ashamed of having spent \$2.4 billion with absolutely nothing to show for it at this point in time. Again, I think that we owe an explanation to our—

**Hon. Deborah Matthews:** That is a completely erroneous statement that you just made. We have made tremendous progress. Patients are benefitting every day from the progress that has been made on eHealth Ontario—60% of family physicians, 40% of community-based specialists. We have an emergency neuro-image transfer system. We have filmless hospitals. Tremendous

progress has been made. For you to suggest that money has been spent without any outcomes that are impacting patients, you are completely wrong. You know you are wrong, and you are intentionally making erroneous statements.

**Mr. Rick Nicholls:** No, I wouldn't put words in my mouth like that, Minister; I certainly wouldn't.

Again, I go back to a statistic of April this year—we're talking about the drug information system—65% of community pharmacies were supposed to be submitting dispensing events to DIS. Right now—zero.

**Hon. Deborah Matthews:** It is late. Nobody is arguing that.

**Mr. Rick Nicholls:** April 12 this year—I know your answer will be, “This is late; nobody's arguing that” as well—but 35% of physicians were to be sending ordering events to DIS and, again, currently zero.

I see money is being spent around here, but there's nothing—nobody's using the system. Where's the value in it? You talked about the narcotic grant, but that is not what we're talking about here in this regard.

I'm going to turn it over now to my colleague Mr. Leone.

**Mr. Rob Leone:** Thank you for that. Minister, I think that the issues that we're raising here are not necessarily related to some of the progress that you've made, but that all of the progress to date has either been very late or very over budget. We have serious concerns with respect to that.

Since we have Dr. King available with us, I would like to ask some questions related to immunization and such. In your estimation, Minister, is Ontario presently prepared, from a technological and information management perspective, for the next inevitable outbreak of a communicable disease like SARS, avian flu or H1N1?

**Dr. Arlene King:** I can answer it in a number of different questions. There has been a lot of, actually, improvements made in the whole area of health protection over the last number of years. Let me just start with the creation of Public Health Ontario, which provides public health evidence to us in support of program and policy development. It has been a really key achievement. The development of emergency management capability within the ministry, supported through Public Health Ontario, is another really important way to be able to coordinate our overall responses to emergencies. Those are two key elements.

The other area that we're, of course, in the process of doing is implementing Panorama, which I made a recommendation on after H1N1 in my report on how Ontario fared in terms of H1N1. You will recall that I made a recommendation that Panorama, which is an information system to record communicable diseases and immunization, be implemented. The government is proceeding with that recommendation, I'm pleased to be able to say.

**Mr. Rob Leone:** I'm curious, Minister: What's the status of Panorama? Do you have an update?

**Hon. Deborah Matthews:** I will ask—

**Dr. Arlene King:** In fact, we just completed a pilot in the Grey Bruce Health Unit that was highly successful. It was a pilot specifically of the immunization module for use in supporting immunizations that are delivered in school-based settings, specifically, HPV—human papillomavirus—vaccine and hepatitis B vaccine. It was resoundingly successful. We, of course, are using the pilots to learn any lessons we need to learn in terms of further system improvements, technological improvements, and to pave the way for further implementation across the province.

**Mr. Rob Leone:** It's my understanding that public health units were supposed to have Panorama up and running by April 2010. I'm wondering, has that happened? If not, why not?

**Dr. Arlene King:** Again, I think that we could get back to you on that specific information. That being said, I'm really confident that the path we're on right now in terms of implementing Panorama will enable us to be successful. We have spent some time over the last few months setting ourselves up for success insofar as ensuring readiness of the field and readiness of the centre to be able to support that. We are certainly on track to be able to implement Panorama with a target date of, I believe it's April of 2013, 2014—that kind of time range.

**Mr. Rob Leone:** Is that for the immunization/vaccine ordering and delivery capabilities, or is that for the communicable disease and outbreak functions?

**Dr. Arlene King:** The first phase of this is the implementation of the immunization-related components, so the actual ability to record vaccines in Panorama as well as vaccine inventory management, followed by the communicable disease elements of that system.

**Mr. Rob Leone:** Dr. King, you had stated previously, and this is a quote that I've received from staff, "We do not have the capacity to track and manage an immunization program. I am absolutely suggesting that on this, we can do better. The technology exists today. It is a pan-Canadian solution called Panorama that has been in development since after SARS.... There must be no more delays. Panorama will allow us to ... respond to outbreaks of disease.... It will give us a 21st-century tool for dealing with pandemics in the 21st century." How close are we to achieving that?

1120

**Dr. Arlene King:** Again, as I said, we've had a pilot implemented in Grey-Bruce. There is an expansion of the pilot planned over the new few months, and we will continue to roll it out as the system is ready for that and as we apply any lessons learned related to rollout. It's a massive undertaking. The system will be rolled out to 2,000 public health professionals, 36 health units and Public Health Ontario. It is a large undertaking, and we will continue to—

**Mr. Rob Leone:** Why haven't the government and public health units had this operational since the deadlines that were previously established: April 2010 for immunization and vaccines; and for the communicable

diseases, several months later than that? Why hasn't it happened?

**Dr. Arlene King:** I should just also contextualize my response with the fact that Panorama is a pan-Canadian solution as well, that was developed through collaboration among provinces and territories and the federal government. We've been working in lockstep with other jurisdictions to ensure that we not only have a solution for Ontario but also for other jurisdictions.

As I'm sure you realize, communicable diseases know no borders. People move a lot, and it's important that we ensure we have a solution that is suitable for all jurisdictions, as well, of course, and importantly, for the province of Ontario.

**Mr. Rob Leone:** I have a question for the minister. Minister, certainly our caucus is very concerned about the status of the Panorama program—the fact that it has been delayed for a number of years, and we've invested money into it already and so on. You have previously stated that "Ontario must enter into two agreements with Panorama's vendors to obtain the software licence and to establish the support and maintenance terms. Without approval, the Panorama project will end, and Ontario will fail to meet its goal of improving the business of public health and will continue operating aging and increasingly unreliable infrastructure. This will result in the loss of over \$40 million invested to date, a lost opportunity to flatten the health care curve, and possible legal ramifications." This is from the Ministry of Health and Long-Term Care scheduling report from December 24, 2010, on page 9.

My question, Minister: Did the Ministry of Health and Long-Term Care manage to enter into a new agreement with IBM?

**Hon. Deborah Matthews:** I'm sorry; can you clarify what it is you're reading from?

**Mr. Rob Leone:** It's the Ministry of Health and Long-Term Care scheduling report. The date is December 24, 2010, and it's on page 9.

**Hon. Deborah Matthews:** I thought you said that I had made that statement, and I was having trouble—

**Mr. Rob Leone:** The ministry stated it. I'm sorry if I—

**Hon. Deborah Matthews:** What scheduling report are you referring to?

**Mr. Rob Leone:** It's the Ministry of Health and Long-Term Care scheduling report from December 24, 2010, on page 9.

**Hon. Deborah Matthews:** We're not quite sure what document that is. Do you have the document?

**Mr. Rob Leone:** At the moment, no. But can you comment on the generality of the comment, since it's coming from your ministry, that \$40 million has been invested to date and there's a lost opportunity to flatten the health care curve? That's what's coming from the document itself. Is there a fear that \$40 million invested in Panorama is going to simply be gone because there has been no agreement entered into with IBM to manage the software licence of Panorama itself?

**Hon. Deborah Matthews:** I will ask my deputy to speak to that particular issue.

**Mr. Saäd Rafi:** I believe IBM was procured by the BC government. The BC government acted on behalf of provinces and territories for the better part of a couple of years, if not longer, in trying to get an agreement that could be signed by all jurisdictions. In the end, several jurisdictions chose to sign on, Ontario being one of them, and Ontario led some of those negotiations and discussions with BC and encouraged other provinces to join on.

Given that we have—I can't remember exactly which provinces now, but BC, Nova Scotia, Ontario, Manitoba, and Saskatchewan as well, I'm told, and now Quebec—that represents a significant portion of the country's population. That represents probably 60% or 70% of the Canadian population.

We do have a licence agreement with IBM, and that is managed individually by each province. Each province chose to have their own licensing agreement, if I'm not mistaken. I don't know exactly about that \$40 million because I can't recall that number, but thus far we have had a very successful implementation, culminating in this pilot rollout that Dr. King has referred to.

**Mr. Rob Leone:** It has been nine years since SARS and the cautionary—

**The Chair (Mr. Michael Prue):** Sorry, I can't even let you start. Time is up.

**Hon. Deborah Matthews:** If I could though, I would like a copy of the report that you are referring to.

**The Chair (Mr. Michael Prue):** Okay. Before we go on, do any other members have questions for Dr. King? I don't want to keep her here unnecessarily. Are there any other questions directed specifically at her? Oh, yes, you do?

**M<sup>me</sup> France Gélinas:** One quick one, and I'll do them right off the bat. How's that?

Dr. King, we've all read the paper. I had asked you to comment on the health effects of windmills in Ontario and you were very nice in doing a report that you made public and certainly made accessible to me, showing that, with the setbacks that Ontario had set, there were no effects of the use of windmills. The federal health government has now decided to do more study, which is never a bad thing, if you ask me. What is Ontario's position now? Is this a file you're monitoring? Where are we at?

**Dr. Arlene King:** Thank you for the question. I think, first and foremost, I just want to say that I stand by the conclusions that I made in my study of 2010. The weight of the evidence does not support any direct health effects associated with wind turbines if they are appropriately placed, and that is with a minimum of a 550-metre setback.

I am aware of Health Canada's study. I'm always open, of course, to looking at more studies. It will be only a contributor, I want to just add, to the overall thinking. There have been more studies that have come out since I issued my report. We will continue to monitor the literature. All I can say at this point in time is that based on the

evidence to date, I do not believe that the weight of the evidence supports any direct health effects associated with wind turbines.

**M<sup>me</sup> France Gélinas:** All right. So if you have been monitoring the "weight of the evidence," in the language you used, can we be expecting a new report coming from you? Because they seem to be very prolific in writing about this subject. It's hard to keep up with everything that comes. I realize that 2010 is not really dated, except that it is a field where people write a lot about the health effects, and I was wondering if you would consider doing an update report?

**Dr. Arlene King:** Again, thank you for the question. I certainly acknowledge, regardless of whether we're talking about immunization or wind turbines or any other public health matter, that the problem is not getting, it's vetting the information. That is the job of public health officials, to wade through that information. I want to say that the weight of the evidence—and the evidence that we look at most conclusively is what's called peer-reviewed literature, where there's a critique actually done of the literature, as opposed to what I would call the "grey literature," where that has not occurred.

With respect to updating my report, should I believe that there are data that enable or should enable any kind of a revision to the report or any of the conclusions in particular, I would issue a new report. But I want to just reiterate that the weight of the evidence does not support any relationship between direct health impacts and wind turbines appropriately sited.

**M<sup>me</sup> France Gélinas:** Has the federal government approached you or other people within public health to participate in the study that they are doing?

**Dr. Arlene King:** The answer is no. I wasn't aware of the fact that Health Canada actually were doing a study until I saw the information myself. I do not have any information. In fact, they are protecting a lot of the information related to the design and locations of where they're doing the study because they want to protect the integrity of the data. So we will find out more about the methodology when the results come out, and we anticipate that would be in 2014.

But I want to just reiterate, this will be just one more study that we will need to look at as we continue to consider this issue.

1130

**M<sup>me</sup> France Gélinas:** Okay. Thank you. I think that was it. I do have a question about public health that I think the minister will be able to answer. The—

**The Chair (Mr. Michael Prue):** Dr. King, you'll have to stay because I've just been given information that a Liberal member has a question when it's their turn. Okay.

**M<sup>me</sup> France Gélinas:** I realize that health units are partly funded by the municipalities, but I would like to know the percentage of provincial funding, by the program area, to each health unit. Is this something I could get—where I would have the 36 health units and find out how much money they get for Healthy Babies and how

much money they get for the different programs that the provincial government funds?

**Hon. Deborah Matthews:** We will undertake to get you that information.

**M<sup>me</sup> France Gélinas:** Thank you. If we could have it for 2011-12, or what it is that you intend for 2012-13.

Going into primary care, I have the same question that I asked about health units. Are there intentions of moving the family health teams into the LHINs? And if so, when can we expect this to happen?

**Hon. Deborah Matthews:** One of the elements of the action plan is to strengthen the role of family health care. If the LHINs' responsibility is to provide the optimum delivery of care in their geographic area, obviously primary care has to be part of that. I think CHCs are already part of the LHINs' responsibility, so we would look ahead. We don't have an implementation plan for this, but we have signalled the intention to bring primary care under the LHINs. I think it's a really important next step. We've come a long way, attaching more Ontarians to primary care providers, but you know that there are still parts of Ontario where it's very difficult to get a family doctor or a nurse practitioner. We know that there are some subpopulations—people with specific language barriers, for example, or people living in poverty—that have more difficulty accessing primary care than others do. As we work to the goal of having everyone attached to a primary care provider, it's important that that work be planned. Currently, a doctor can set up a practice wherever he or she wishes to do that. We want to have more planning under the umbrella of the LHIN.

We also know that one of the big problems in our health care system is that those hand-offs of care, say, from hospital back to community, are not nearly as strong as they should be. For example, when someone leaves the hospital, they may very well need a follow-up with their family care provider. In some cases, that follow-up isn't happening at all or is happening too long after they've left. There's a lot of work that has to be done to bring primary care into the overall health care system. We need the advice from those family health care providers. They see first-hand where the problems are, and they can be part of the solution.

Another area where our primary care doctors are not having the smooth access to care for their patients is when they need to refer to a specialist. Doctors spend too much time—

**M<sup>me</sup> France Gélinas:** You're going further and further away from my question.

**Hon. Deborah Matthews:** Sorry. You're asking when they will be brought under the umbrella of the LHIN. This is something we're working on now.

**M<sup>me</sup> France Gélinas:** It wouldn't only be for family health teams; it will be for all primary care organizations, as well as solo? Eventually they will all come?

**Hon. Deborah Matthews:** Doctors will continue to be paid by the ministry, but the planning and integration will involve, ultimately, all our primary care providers.

**M<sup>me</sup> France Gélinas:** Can I have a breakdown of the non-physician health professionals working in family health teams? You had done this the last time, and it was most useful, where we see—

**Hon. Deborah Matthews:** By profession?

**M<sup>me</sup> France Gélinas:** By profession, yes.

**Hon. Deborah Matthews:** We can probably do that.

**M<sup>me</sup> France Gélinas:** Actually, I wouldn't mind having the number of physicians also, but I don't want just physicians and non-physicians. I would like them by nurse practitioners and nurses and social workers etc. That would be useful.

I take it that we still keep a list of underserved communities. For some reason, I can't find it. So I'm going to ask you now, do we have a list of underserved communities, and could I have a copy of it?

**Hon. Deborah Matthews:** We changed the Underserved Area Program, and when we did that—well, let me find out. We'll check and see.

**M<sup>me</sup> France Gélinas:** If we do have a list of underserved communities, I would also be interested in knowing, do we keep track of how many people don't have access to primary care and don't have a family physician? We used to be able to link those two. That information is not where it used to be anymore; we can't find it. How many communities are underserved and how many people don't have access?

**Hon. Deborah Matthews:** On whether people are looking for a family doctor or not, we have Health Care Connect. So if people do register with Health Care Connect, we've got those numbers. If they don't register, it's more difficult. We do have, I believe, a survey that is done to determine how many people are without family doctors. But with Health Care Connect, those are real numbers because those are real people, and they are available by LHIN.

**M<sup>me</sup> France Gélinas:** I know that you've changed the definition of underserved. It used to be that we would know that such-and-such community had 3,000 people and they had no family physician; they were underserved for 15,000 people or 5,000 people. This information used to be available in that format. If it's still available in that format, I would certainly like to know the list of communities that are underserved, and for how many people, as well as the survey you're talking about that gives us the number of people who are unattached.

**Hon. Deborah Matthews:** We'll see what information we can get on that issue now.

I can tell you that one of the reasons that it's important that the LHIN take on that responsibility is that it's very hard, from downtown Toronto, to understand each community. Not every doctor takes on the same number of patients. Some doctors are working part-time. We have retirements. There are a lot of moving parts. So the more we can get that planning to the local level, the better information we'll have.

**M<sup>me</sup> France Gélinas:** You'll remember that the auditor did a special piece on family health organizations, and the ministry actually answered his recommendations.

I was just wondering, are we on target, especially the recommendation of recouping some of the cost that had gone?

**Hon. Deborah Matthews:** The answer to that is yes. I believe we've recouped \$121 million. We'll confirm the number. We have a pretty rigorous process, that if money is not spent—because, for example, maybe they haven't been able to fill a position—then we do recoup that money.

Having said that, the Auditor General gave us very good advice, and as always, we are taking that advice very seriously.

**M<sup>me</sup> France Gélinas:** Sounds good.

I'm going to be talking about nurses for a little while. Whether it's HealthForceOntario or the Nursing Secretariat, do we have any current studies regarding the skill mix and changes in the nursing staff in Ontario's hospitals?

**Mr. Saäd Rafi:** We know the number of NPs, RNs and RPNs in that mix and how that mix has been tracking in terms of growth. I just don't know it by hospital, in terms of the mix within the hospital—or of hospitals across the province.

**M<sup>me</sup> France Gélinas:** If I could have those trends in whichever way you have, it will be a good step—the mixes of nurses within the hospital sector. If you have it by LHINs or you have it by big, small, rural hospitals etc., whatever breakdown you have, I would be interested—and all you have is for all, and I'll take what you have.

Do we have any studies that look at future supply and demand for nurses in Ontario?

**Mr. Saäd Rafi:** Yes, we can get you that.

**M<sup>me</sup> France Gélinas:** Okay, I would be glad to see that.

Then, in May this year, we talked about how 900-plus nurses were to be hired. Do we know the numbers out of those 900 that have been hired now?

1140

**Mr. Saäd Rafi:** The short answer is yes.

**M<sup>me</sup> France Gélinas:** And a number will come—

**Hon. Deborah Matthews:** And we know where they are, in what field: 144 of them are working in our school boards on mental health. I think there are 200 who are part of the behavioural supports initiative to support people, particularly in long-term-care homes, who need special behavioural supports. So we're hiring nurses. There are public health nurses—there are a range of them.

I thought I could put my fingers on it, but let's see if we can get that information for you.

**M<sup>me</sup> France Gélinas:** I would like to know, let's say of the 144 in schools, how many of them have actually been hired. Do we know if there are actually bodies in those positions? The same thing with the 200 behavioural nurses. Has the money flowed? Have they been hired? I would be interested in knowing where we are at, and knowing the full breakdown as to where the 900-plus are going to be allocated.

The last one is the 900 new nursing positions that were announced way back. What is the actual number of new nurses that were hired? Do we keep track of those by nursing classification, as in, how many were RNs and how many were RPNs etc.?

**Hon. Deborah Matthews:** Again, we will endeavour to get you that detailed information.

I think the other category of nurses that I'm pretty excited about are the care coordinators, specifically to ensure that people with complex conditions who are being discharged from hospital get a visit from that care connector within 24 hours of discharge from the hospital to make sure that they are getting the follow-up care that they need.

There are a number of initiatives that are really part of the transformation of the health care system to provide better care at the right time, in the right place. We will undertake to get you those—though I think maybe the deputy has—

**M<sup>me</sup> France Gélinas:** Oh, okay.

**Mr. Saäd Rafi:** One should be careful about reading out something that's thrust in front of you. With that proviso, I'm trying to get a year here, so that's why I'm—pardon me. From 2010-11—these are just family health team nurses.

**Hon. Deborah Matthews:** But that's the breakdown by specialty that she'd asked for earlier.

**Mr. Saäd Rafi:** Yes, sorry, it's a different question; you're right. This is by the family health team professionals that you were looking for.

**M<sup>me</sup> France Gélinas:** But 2010-11—I think I already have those.

**Mr. Saäd Rafi:** It's 2010-11 and 2011-12.

**M<sup>me</sup> France Gélinas:** And 2011-12?

**Mr. Saäd Rafi:** Between those two years, as to what was approved, what was hired. We'll get this to you as opposed to me reading it out. I'm sure someone would want me to read it out, but since it was just thrust in front of me, I'm cautious about that.

**M<sup>me</sup> France Gélinas:** Okay, that would be good. If you could give me 2010-11 and 2011-12. I think you've already shared with me 2010-11, as to how many positions had been funded. I'm not sure I ever knew how many were actually hired.

**Mr. Saäd Rafi:** About 88% have been hired against those approved.

**M<sup>me</sup> France Gélinas:** Okay.

**Mr. Saäd Rafi:** In addition to these 3,000 approved, 2,600 hired, there are 2,400 physicians who are also working with an enrolment of approximately 2.8 million patients across those family health teams.

**M<sup>me</sup> France Gélinas:** But I will get more details as to social workers, dietitians and all the rest?

**Mr. Saäd Rafi:** You will, but offhand, there are 339 mental health/social workers. RPNs are, of course, far fewer than RNs and NPs. But the highest hiring rates would be in social workers, dietitians and all nursing, verging on 88% to 90% hired against approved.

**M<sup>me</sup> France Gélinas:** Okay.

**The Chair (Mr. Michael Prue):** You have 45 seconds left.

**M<sup>me</sup> France Gélinas:** Forty-five seconds? Oh, all right. I wanted to go into home care, but I'll just put out one question and—

**Mr. Saäd Rafi:** I could answer your CINOT question, if you'd like.

**M<sup>me</sup> France Gélinas:** Oh, can you? Well, why don't you do that?

**Mr. Saäd Rafi:** It's not how the manual goes, but CINOT allocation in 2011-12 was \$3.9 million—spent, excuse me, in 2011-12, was \$2.8 million; allocation in 2012-13 is \$3.9 million. Healthy Smiles allocation in 2010 was \$29.5 million—sorry; I may have the numbers reversed. I think allocation should be \$27.9 million. No, no, pardon me: allocation, \$29.5 million; spent, \$27.9 million. In 2011-12: allocation, \$30 million; spent, \$25.8 million. The 2012-13 budgeted allocation is \$30 million.

**M<sup>me</sup> France Gélinas:** Okay.

**The Chair (Mr. Michael Prue):** Okay, I'm going to have to stop you there. It is now the turn of the government. I understand Mr. Craitor has the first question.

**Mr. Kim Craitor:** Dr. King, I had a question of yourself, so thank you for staying a little longer. I did not expect you to be here, and I'm really pleased that you are. I didn't expect the subject of wind power to come up, and I'm really glad that it has, because you are here.

Just a couple short things: As you know, we're inundated as politicians—against it, for it, all those type of things. There are people who passionately believe that it has huge health care problems, and there are others who tell us studies galore have shown the opposite. I know there are people back home who are watching this in my riding because wind power has become very prolific; a number of industries have opened up.

I want to ask you this, just to have it on the record, and I want to be able to comment when I go back to my riding that I had a chance to speak to you in person. You produced a study; it's independent of the government. It's not something where we gave you the data—when I say “the government,” I mean our party—and said, “Here's what we're giving to you. We want you to review what we're giving to you. We want you to produce a report for that.” Yours was done completely independent of any of the parties. Am I correct?

**Dr. Arlene King:** Yes.

**Mr. Kim Craitor:** When you do a study like that—whether it's on a drug or some type of new service that's coming in—can you just quickly tell me: How do you put it together so you can analyze it? Because you could have come up with the opposite point of view if you had had data that would have showed that. Do you mind taking a moment and just kind of explaining for the public how that works?

**Dr. Arlene King:** I'll tell you specifically how and why I did the study. First of all, there were a lot of concerns being expressed by the population about alleged health concerns related to wind turbines in the province of Ontario. I also was concerned about the fact that there

was a lot of misinformation out there as well. That's why I convened a group of people together: a group of medical officers of health out there in the province who had an interest in this topic, expertise from Public Health Ontario and expertise within the ministry, to compile all of the literature on this topic—the literature was from about 1970 to the present time—to look at all of the literature that existed, both peer-reviewed and what I talked about before, which was grey literature. They reviewed all of it for its strength, and came up with a conclusion which is not at odds with the conclusion of most other reputable health organizations, like the World Health Organization, as an example. The institute of public health in Quebec has recently done a review as well and concluded that the weight of the evidence did not support any link between direct health outcomes and wind turbines. So that's generally how it was done.

It was done over quite a number of months—I can't remember exactly how many months we pulled the literature together—and then issued the report. The reasons were as I outlined: concerns being expressed by the public about wind turbines and the health impacts. Also, I felt that there was a great deal of misinformation that existed out there.

**1150**

If I can make one other point too, which I think is quite an important one, it's that coal-burning produces a lot of air pollutants, and we know that the air pollutants produced as a result of burning combustible fuels like that do definitively result in adverse health impacts. Wind, on the other hand, is a clean, renewable source of energy, and it doesn't produce any pollutants, as well.

Again, it would be expected that promotion of greener energy alternatives over time would in fact reduce the incidence of adverse health effects as well. It's always important to put that in context in terms of what our alternatives are, related to something like a clean energy like wind.

**Mr. Kim Craitor:** Thank you. Thank you, Mr. Chair.

**The Chair (Mr. Michael Prue):** Thank you. I'll just check one last time: Are there any other questions of Dr. King? You will have some?

*Interjection.*

**The Chair (Mr. Michael Prue):** Then you'll have to stay. You've touched on a lot of things here, obviously.

Back to the government.

**Mr. Phil McNeely:** Chair, could we juggle the time to let the person leave, and just take it off our time and have the questions asked, with the agreement of the other members here?

**The Chair (Mr. Michael Prue):** You want to allow your time to be used by other members?

**Mr. Phil McNeely:** I think within limits, but I think it's important that the medical officer of health leaves; it's the urgent nature of her business. If we could do that, it would be very helpful.

**The Chair (Mr. Michael Prue):** Is there consent of the members to do that, to use Liberal time? Okay.

I'll first turn to the Liberals. Are there any other questions of Dr. King?

Seeing none, we'll turn to the Conservatives. Are there questions of Dr. King?

**Mr. Rick Nicholls:** Yes, Doctor, it's nice to have you here today too. It was a pleasant surprise.

Since the mention of turbines has in fact come up, obviously, from a health perspective point of view, turbines in my riding of Chatham-Kent-Essex—it's huge. Probably by the end of 2013, if not 2014, there will be over 500 turbines in a relatively small, compacted area.

Of course, as we know right now, the government has chosen to maintain control as to not allowing municipalities to decide whether or not turbines are to be built. As a result, though, recognizing that turbines are a relatively new form of renewable energy, sometimes it takes years—months, if not years—to determine or ascertain whether or not there are health effects caused by, in this case, wind turbines.

It's a very sensitive, highly emotional but also factual concern back in my riding. People are suffering from sleep deprivation, ringing, buzzing in the ears—children are saying, “Mommy, when are the bees going to stop buzzing in my ear?”—dizziness, vertigo and other associated illnesses. Recognizing that maybe—I believe you called it grey paper—

**Dr. Arlene King:** Grey literature, yes.

**Mr. Rick Nicholls:** Grey literature, yes. I respect that; I do. However, one of the things I found, based on having been in business for a number of years as well—not in health but in business—is that sometimes I've had to change my direction, based on new information. I appreciate a comment that you'd made earlier, that you stand by your statement of 2010—that's two years ago now. At that time, turbines were relatively new in areas. Perhaps data may be changing.

I do have information—unfortunately, I wasn't aware that you were going to be here today. I can get you the information from the World Health Organization, which has done complete studies as well—I'm sure you've looked at those studies—in terms of what their findings are. We are finding that, in fact, turbines are creating more and more.

Now, to the minister's point, you talk about increasing health care. Turbines may be, in fact, compounding a problem in the health care field, based on the effects of wind turbines, so it may be adding to your costs down the road. I don't have hard data for that, Minister, and I'm not asking to provide it. I'm just, as they say, throwing it to the wind right now—no pun intended. Yes, it was intended. I just fairly want to mention that to you.

Again, to Dr. King, you've mentioned that there are other studies. We now know that Health Canada has jumped in. To me, when suddenly Health Canada jumps in, it's implying anyway that they're beginning to listen more and more, as I'm sure you are, to the new health concerns that are coming up relative to wind turbines in areas throughout Ontario and, of course, with Health Canada, throughout our great country.

Again, I would just ask, Doctor, that perhaps closer consideration be given to the findings and listening to the people. We've had town hall meetings down in our area, as in other rural areas. It isn't happening in the larger cities, for obvious reasons. Again, we have to listen to rural Ontario, because in fact what we don't want to do is become a burden to the health care system in the event down the road that it is identified, and I don't know—did your study identify the effects of low-frequency vibration?

**Dr. Arlene King:** Let me sort of step back and give you a little bit broader answer to some of your questions.

First of all, the decisions with respect to renewable energy policies are made by the Ministry of the Environment and the Ministry of Energy. My job is to look at whether or not, if I feel there is a need to do so—to determine whether there are health impacts associated with some of those policies, which is what I did.

Now, the literature on wind turbines does date back, and we looked back to the 1970s, so there's particularly a fairly extensive amount of literature in Europe related to this issue. A lot of the literature came from Europe, but it also came from whatever was available in North America as well.

When it comes to reaching conclusions—and I talk about the weight of the evidence. It's not just “a” study. Often, what the media does is popularize a study of the day. We look at the whole suite of literature that's available and look at—when I say “the weight of the evidence,” there's a number of different criteria that we use to actually evaluate that evidence. They're called the criteria of causation, actually, which enable us to look at things like coherence with other information that we have, what the strength of the association might be. Did the putative health impacts that are in question precede or follow the exposure? Is there a dose/response relationship, meaning that if you get more of that, are you worse off than if you get less—those kinds of considerations. That's the way we in fact evaluate the literature, and that's how we looked at the literature related to wind turbines.

I will acknowledge that there are some people who have been annoyed—and I stated this in my report—by the presence of wind turbines, and annoyance can result in some symptoms that you're describing. Now, I'm not saying that for the individuals who are experiencing those symptoms, their symptoms are caused by annoyance, but we have to recognize that annoyance in fact can lead to symptoms like sleep disturbance and some of the other symptoms that—

**Mr. Rick Nicholls:** So, in fact, some people are more susceptible to, say, wind turbine disturbance than others, based on just their own hearing and sensitivities and so on?

**Dr. Arlene King:** Again, there isn't any evidence that the low-frequency sounds that you're talking about—and those are the ones, I think, that are of particular concern; the sounds themselves—that there's any adverse health impacts associated with the low frequency. We actually

did look at that concern related to what are called low-frequency sounds as well. Yes, people are more susceptible at times, I think, to annoyance.

I just want to cite one other piece of literature, though, that we did look at. Wind turbines have been around, as I mentioned before, for a long time in a number of places, particularly parts of Europe. Studies in Sweden and the Netherlands found that wind turbine sound is annoying to some people, particularly people with a negative attitude to the visual impact of wind turbines. Also, importantly and conversely, the direct economic benefit from wind turbines was associated with decreased annoyance as well. So there are factors that influence whether or not people are annoyed by wind turbines.

**Mr. Rick Nicholls:** Okay. So the economic thing you mentioned was maybe relative to “no-cheque-itis,” which is “no cheque.” They’re not receiving economic benefit.

The other part, though, is psychosomatic. You’re suggesting that it may be kind of like in their heads, so to speak. They get annoyed; they have a bad attitude. They get annoyed; it creates stress, high blood pressure and those types of things. All right—

**Dr. Arlene King:** Again, I don’t want to imply, though—it’s always important. As Chief Medical Officer of Health, of course I take people’s health concerns seriously, and I don’t want to imply that people don’t have some of these symptoms. I’m suggesting that some of those symptoms can be related to annoyance. I think if people have persistent symptoms that they not just attribute them to annoyance, however, that they actually go and get assessed, as well, by their medical practitioner to make sure that they don’t have any kind of other health condition as well.

1200

**Mr. Rick Nicholls:** Sure. Listen, I want to thank the Liberals for allowing us to ask a question of our medical officer. Thank you.

**The Chair (Mr. Michael Prue):** Okay, and I see that the NDP now has a question.

**M<sup>me</sup> France Gélinas:** Mine is very short and has nothing to do with windmills. It has to do with your 2010 annual report. In your 2010 report, you talked about health impact assessments and health in all policies as a way to do health promotion and chronic disease management. I was wondering if you have noticed any pickup or any improvement using health in all policies or using health impact assessments.

**Dr. Arlene King:** This is a really important question that you’re asking. In fact, the government has worked on developing a health impact assessment tool. They worked with public health units as well to develop that health impact assessment tool, and we are encouraging both the health sector as well as the non-health sector and public health—that’s three sort of discrete bits—to actually use these health impact assessments in the course of their work. So there is definitely more uptake on that. I think that the question is: How do you best do that? How do you best do those health impact assessments? Juris-

dictions have chosen a number of different ways of doing that.

With respect to all of government activity, absolutely. I think more and more people are thinking across ministries and the various parts of government that need to be addressed to engage in a health issue. That is happening more and more, and I’m really heartened by that. I spend a lot of time, in the course of my work, talking to other ministries because, as I said in my report, the non-health sector has a huge impact on the health of the population, and we need to acknowledge that.

**M<sup>me</sup> France Gélinas:** So those health impact assessment tools, are they accessible online? How would a group know about them?

**Dr. Arlene King:** I believe that our health impact assessment tool, actually, is available online, but we’ll have to get back to you in terms of the status of the health impact assessment tool work that has been done. I’m just not 100% sure, but I believe that it is publicly available, the work that has been done.

**M<sup>me</sup> France Gélinas:** Sounds good. Those were my questions. Thank you.

**The Chair (Mr. Michael Prue):** Any questions arising from that from the Liberals? Okay, seeing none, thank you very much, Dr. King.

The Liberals have four minutes left.

**Mr. Phil McNeely:** Chair, could we get a little bit more than that?

**The Chair (Mr. Michael Prue):** No, you gave it up voluntarily.

**Mr. Phil McNeely:** For a good cause.

Back to you, Minister: I have some questions on eHealth. What is the extent of telemedicine use in Ontario?

**Hon. Deborah Matthews:** As I said earlier, telemedicine is a very important innovation in Ontario. I believe there were—how many, last year—144,000 consults. I believe there are 200 different specialties that can be accessed through the Ontario Telemedicine Network. It is showing to provide excellent care for people closer to home. This is an innovation that I think Ontarians should be very proud of, and is improving access.

We tend to think of it as something that’s used in remote parts of Ontario, but it’s actually used throughout Ontario, and I just think that we’ve got a lot of potential to do even more remotely. We find that patients, actually, are very satisfied with the care that they are receiving that way.

**Mr. Phil McNeely:** What are filmless digital scans? What do they mean for the health care of Ontarians?

**Hon. Deborah Matthews:** What that means is that if you have an X-ray or an ultrasound or a CT scan or an MRI in a hospital, that information is now collected electronically.

I think you and I will remember when, if you went in and had an X-ray on your leg, you’d actually carry the film with you.

**Mr. Phil McNeely:** I still have mine from 2003.

**Hon. Deborah Matthews:** You have the film? Well hold on to it; it'll be worth something some day.

**Mr. Phil McNeely:** I had a knee replacement—but that's good.

**Hon. Deborah Matthews:** That's no longer done on film anymore. It is making a terrific difference, because what would happen now is that you would have that information. That information on you, on your knee, would be captured electronically. When you went to see your specialist, they would be able to access not just the X-ray you just had done but the one you had two years ago and two years before that. With the click of a mouse, they can see how you're doing over time.

It has reduced the need for duplicate tests, because that information is available electronically. Not only is it collected within the hospital, but it is collected in many parts of Ontario and will be all parts of Ontario at a regional level. In southwestern Ontario, I think 34 hospitals are all hooked up to SWODIN, Southwestern Ontario Digital Imaging Network. These images are held in a central repository and anybody can access them.

It allows someone to go into a smaller hospital without all the expertise of a large academic health science centre, and that image can be interpreted by someone who might have a higher degree of experience and skill in a particular speciality.

This is a remarkable transformation. When we think about where our health care system is going, we will be able to achieve the success we need to achieve if we capitalize on the changes in technology that are available in health care. This is a really good example of an eHealth success that is providing higher-quality patient care, reducing unnecessary testing and saving money.

**The Chair (Mr. Michael Prue):** I'm going to have to stop you there. Thank you very much.

**Mr. Phil McNeely:** Thank you, Chair.

**The Chair (Mr. Michael Prue):** And on to the Conservatives.

**Mr. Michael Harris:** Thank you, Mr. McNeely. You've raised another important issue with regard to eHealth, and that will be the continuation of our questioning.

Minister, this morning, you referenced, on page 7, keeping Ontarians healthy. You brought up the diabetes segment. My questioning will relate to the diabetes registry of eHealth. That, in fact, was actually an initiative that was announced to much fanfare by the former health minister, David Caplan, who, unfortunately, was a victim, or was a minister who was fired for his handling of eHealth. I'll just remind the committee of that.

Could you tell the committee the original target date for implementation of the diabetes registry?

**Hon. Deborah Matthews:** I think you know that Infrastructure Ontario is responsible, working with eHealth Ontario, for the procurement.

**Mr. Michael Harris:** I do realize that, Minister, but you direct Infrastructure Ontario. You should know the target date for implementation of that registry. What was that target date?

**Hon. Deborah Matthews:** I think you're getting to the point where you're going to say that this project is late—

**Mr. Michael Harris:** We'll get there, but I'd like to know what the target date is first.

**Hon. Deborah Matthews:**—and you are absolutely right. I am enormously disappointed that the vendor was unable to deliver this product on time.

This is an AFP procurement. I can tell you that this project is being managed as well as it can be, given that the vendor has not upheld their end of the bargain. But what I can tell you is that an element of the contract with the vendor is that we do not spend one penny until we receive the product, so we have not spent any money on the diabetes registry and will not until that project is delivered exactly to specification.

**Mr. Michael Harris:** Just for the committee's knowledge, because you weren't able to answer it, the target implementation date was actually April 2009. When was the vendor selected for that registry?

**Hon. Deborah Matthews:** I think what I want to do is just clarify that there have been significant changes at eHealth Ontario: a new chair, a new CEO, a new board. When they came into the positions of responsibility that they have now, they took a very hard look at the projects they had under way. They were responding to the Auditor General's recommendations. As a result, they made some changes as to what projects they would be focusing on. They reduced the number of projects that they were working on, and are phasing them in.

**1210**

Under the new leadership, in response to the Auditor General's recommendations, there was a new strategic plan developed that lays out sequencing for these initiatives, all building towards the goal of all Ontarians with an EMR by 2015. But they are doing it in a way that is planned and responsible.

There have been changes, and that is public information that they are moving forward, as well they should be, in a very deliberate way.

**Mr. Michael Harris:** Agreed. The original target date, again, was April 2009. I had asked you when the vendor for the registry was actually selected. That wasn't until August 2010, so that's a significant duration afterwards.

I'm not sure if you've had an opportunity to read a Sun column by Jonathan Jenkins, where he talked about—the headline was “eHealth Needs Surgery.” In there, he goes on to talk about many of the deadlines that were missed regarding this important diabetes registry. In fact, there were five implementation deadlines. Can you explain how we've missed five deadlines?

A part of the agreement with the company—is it CGI that is the selected company that's working on this?

**Hon. Deborah Matthews:** I believe so.

**Mr. Michael Harris:** In that agreement, there were to be reports issued to eHealth as to why there was a delay. As per that agreement, you've likely received five reports indicating the reasons for the delays. Will you table those

reports to this committee as to why those delays occurred?

**Hon. Deborah Matthews:** Let me turn to the deputy; I'm not sure what it is.

**Mr. Saäd Rafi:** Again, I would just say, similar to other requests, if that's what the committee would like to have—I'm not familiar with that exact number, but if that's what the committee is requesting, we will do our best to comply.

**Mr. Michael Harris:** We'd like it, obviously, in a timely fashion. Would you say in a week's time, a week from today, we'll be able to get those reports? Would that be sufficient time?

**Mr. Saäd Rafi:** We have 30 days after the conclusion to supply questions, so I just want to use a certain—

**Mr. Michael Harris:** Thirty days is fine.

**Mr. Saäd Rafi:** I'm up to 26 different requests for information, which are fairly extensive, so I'm just—

**Mr. Michael Harris:** Well, you've got a big ministry. I'm sure you'll have staff to support that request of the committee.

**Mr. Saäd Rafi:** And many things to do, as well.

**Mr. Michael Harris:** You were saying how it was a colossal failure, basically, to get this off the ground—

**Hon. Deborah Matthews:** Excuse me.

**Mr. Michael Harris:** I'll say it's a colossal failure, then, to get this off the ground.

**Hon. Deborah Matthews:** Thank you.

**Mr. Michael Harris:** Why is CGI still the company that's involved in this if, from your earlier statements, the company was responsible for the delay? Obviously, there were delays from the ministry and eHealth to get this off the ground. Why is CGI still working on this file, then? Do you have faith, still, in CGI to execute the diabetes registry in Ontario?

*Interjection.*

**Hon. Deborah Matthews:** Yes, I will.

**Mr. Saäd Rafi:** It's my understanding that eHealth Ontario and CGI feel that they are still able to produce the first phase of the diabetes registry, which is a limited production release and—

**Mr. Michael Harris:** When do you figure that will be? What's the deadline or target for that?

**Mr. Saäd Rafi:** I don't have that at my fingertips, but it will be part of the response that we will provide.

They are confident that CGI has the ability to provide the product, but also, CGI is contracted to do so under a partnership model that, as the minister mentioned, means that payment comes on substantial completion. Substantial completion is a production release that is acceptable to eHealth Ontario, as is my understanding. They believe that they can deliver that.

**Mr. Michael Harris:** Are you aware that CGI, actually, was the same company employed to execute the federal gun registry that, again, was also a colossal failure?

**Mr. Saäd Rafi:** No, I didn't know that—

**Mr. Michael Harris:** Well, they are. They were.

What percentage of diabetes patients are currently registered under this registry?

**Mr. Saäd Rafi:** The production release has not come out yet so we aren't actually registering those patients. We'll register those patients once the registry has been built. We've been using data that's available to eHealth Ontario to test drive, if you will, the software solution that has been designed thus far.

**Mr. Michael Harris:** To your understanding, what was the most recent date for the registry's full deployment?

**Mr. Saäd Rafi:** I don't have that at my fingertips. I'll have to get—

**Mr. Michael Harris:** Okay. That's obviously an important—we want to be able to measure. I think Ontarians have spent an awful lot of money.

I will go back, just quoting a reference, to correct the record. Smart Systems for Health agency began actually operating in 2003, which turned into eHealth in 2008. You referenced the Auditor General's \$800 million that was issued to Smart Systems for Health. I'd like to state for the record, in fact, that it was your government that operated Smart Systems for Health agency five out of the five and a half years of its operation. Just for the record, I want to state that.

**Hon. Deborah Matthews:** I was just quoting the Auditor General.

**Mr. Michael Harris:** And I'm simply quoting the fact that your government operated Smart Systems for Health five out of the five and a half years.

I'd like you to get back to me on that full deployment date in terms of the last deployment. I believe it was January 2011, and it's July 2012, so we're very much off course. I know there were a lot of changes at eHealth. I believe the new chair came in at the tail end of 2010 and—you know what?—now we're at 2012 and diabetic patients in Ontario still have no registry.

I'd like you to comment, Minister, on the following statement. You spoke this morning of your work with the Canadian Medical Association or the Ontario Medical Association, but I want to reference a Canadian Medical Association Journal in June of this year: "But critics say the overdue registry has been beset by procurement mis-cues, surpassed by technological change and may already be worthy of being ditched as yet another example of a centralized approach to eHealth run amok and having little clinical merit."

That was the Canadian Medical Association Journal, June 2012. What do you have to say to that?

**Hon. Deborah Matthews:** I presume you're referring to an article published in that journal.

**Mr. Michael Harris:** I am.

**Hon. Deborah Matthews:** Who was the author of that?

**Mr. Michael Harris:** Canadian Medical Association Journal 2012—

**Hon. Deborah Matthews:** No, no, they were not the author of the article.

**Mr. Michael Harris:** I don't have that information but I'm sure it's available.

**Hon. Deborah Matthews:** If you could get that—

**Mr. Michael Harris:** You've got staff. You can ask—

**Hon. Deborah Matthews:** Excuse me, if you quote from a document in committee, you are obliged then to provide that document. Please do that.

What I can tell you is that our diabetes strategy is rolling out.

**Mr. Michael Harris:** When is your deadline for that strategy rollout, then?

**Hon. Deborah Matthews:** There are different components to the diabetes strategy. The regional coordination centres are up and running. They are providing very intense wraparound service for people with diabetes. I know that Mr. Dhillon is here from Brampton. There's one at William Osler that is receiving excellent reports from patients who are benefitting from that care. The Centre for Complex Diabetes Care—that's at William Osler. The regional coordination centres are bringing in a range of supports for people with diabetes because, as you know, people with diabetes have different health care needs.

Finally, they are being coordinated, and we are supporting people to manage their own disease to slow down the progression of diabetes and maybe even halt the progression of their diabetes with appropriate management. We've got diabetes education programs, diabetes education teams. Diabetes is a disease that we can manage much, much better than we currently are, so we're making progress.

**Mr. Michael Harris:** But Minister, we can't manage this—a big part of this is the diabetes registry. I mean, how can we manage something—

**Hon. Deborah Matthews:** That is one component of it.

**Mr. Michael Harris:** You know what? Year after year after year, eHealth and your ministry continue to let Ontarians down in getting this together. We've missed target dates and implementation dates big time. The goal of the registry is to track indicators such as blood sugar and cholesterol levels, kidney function and eye exams for an estimated 1.1 million Ontarians with the disease and then link that information to all the health care providers who work with the individual patient. I mean, 1.1 million Ontarians who have diabetes are in desperate need of this registry to not only help them but, obviously, to provide efficiencies in the overall system.

I'll read you another quote by—

**Mr. Phil McNeely:** Mr. Chair, if we're going to be reading documents, the minister has to see them before the questions are asked.

1220

**Mr. Michael Harris:** I'm just referencing—

**The Chair (Mr. Michael Prue):** If she wishes them.

**Mr. Michael Harris:** I'm reading—

**Hon. Deborah Matthews:** And she does.

**Mr. Michael Harris:** I'll read a statement. Darren Larsen, who you also suggested work with—he's a senior

peer leader at OntarioMD, which is overseeing the installation of a \$236-million electronic medical records system for 11,000 physicians: "The diabetes registry will never be used unless it is compatible with physician EMRs.... 'Anything they build that is outside the EMR will not be used much.' But until four months ago, the registry team 'had never seen an EMR. That surprises me.'" What do you say to that?

**Hon. Deborah Matthews:** I would very much appreciate seeing the document you're reading from and—

**Mr. Michael Harris:** It was a quote that he'd said for—

**Hon. Deborah Matthews:** What I can tell you is that your suggestion that people with diabetes cannot have their condition managed by their primary care providers—

**Mr. Michael Harris:** I didn't—no, now you're putting words; I did not say that.

**Hon. Deborah Matthews:** No, what you said was that the 1.1 million Ontarians with diabetes are not getting appropriate care.

**Mr. Michael Harris:** No, I didn't say that. Minister, I did not say that.

**Hon. Deborah Matthews:** Well, we could look at Hansard.

**Mr. Phil McNeely:** Point of order.

**Hon. Deborah Matthews:** What I am telling you—

**The Chair (Mr. Michael Prue):** We have a point of order here. Mr. McNeely?

**Mr. Phil McNeely:** Mr. Chair, I think it is the custom that those documents are produced before the questions are asked from them. I think we need those documents. It doesn't take long to reproduce them. We should all have the benefit of them as this progresses.

**Interjection:** We should all get a copy.

**The Chair (Mr. Michael Prue):** Some of this is just a quotation. I would ask the member, Mr. Harris, over the lunch period, if he has some documentation, to bring it forward for your next round of questioning and to make sure that the minister has an opportunity to review them, if you have those documents. If you don't, then I would think the question is moot, because the minister is not obliged to answer something that she doesn't have.

**Mr. Michael Harris:** I'm simply asking her to comment on a statement that I have just read, and I'd like to hear her answer on that.

**Mr. Phil McNeely:** I think it's important, Mr. Chair, to see the context of the quotation.

**The Chair (Mr. Michael Prue):** The minister is the one who has to—your point is well made, but it is the minister who has to invoke that, if she wants to see it. If she simply says, "I can't answer it, because I don't have the document," that's an answer in and of itself.

Mr. Dhillon, on the same point.

**Mr. Vic Dhillon:** Chair, it's also relevant for us, as we may want to comment on what the entire gist of the story or the document is. It's not just for the minister.

**Mr. Michael Harris:** We'll go to the library. There's a magazine in there which has this quote, so we'll photo-

copy it and get it to you, if you want to read it. But my questioning is directed to the minister. So we'll move beyond that, I guess.

**The Chair (Mr. Michael Prue):** All right. Over the lunch hour, if Mr. Harris is able to find it, he will make copies and we will have it distributed to the members. If he can't find it—

**Mr. Vic Dhillon:** And then perhaps he can ask his questions after we have the documents.

**The Chair (Mr. Michael Prue):** Yes.

**Mr. Michael Harris:** So, Minister, I'm not suggesting that those patients are not getting the proper care. In fact, I just simply stated that this diabetes registry that your former colleague—one who in fact was fired for this colossal failure of eHealth—bragged about, and yet, years and years later, we still don't have—tell me what percentage of diabetic patients in Ontario have had their profiles uploaded to this registry. Can you answer that?

**Hon. Deborah Matthews:** I sure can, because the registry is not operational.

**Mr. Michael Harris:** So, none.

**Hon. Deborah Matthews:** Of course.

**Mr. Michael Harris:** So, nobody in Ontario.

**Hon. Deborah Matthews:** I believe the deputy already answered that. We have collected baseline data from our primary health care providers on their patients with diabetes.

**Mr. Michael Harris:** Again, a deadline of implementation in 2009; the vendor wasn't selected until 2010. The last deadline it was to be rolled out was January 2011; it is now July 2012. Ontarians want to know how much more money they're going to have to sink into this. Although you say CGI hasn't been paid a dime, I can assure you that Ontarians have paid through eHealth time and time again for the development of such a registry. How long are you going to tell folks with diabetes that they're going to have to wait for this registry that will really help them? How much longer? Tell me that today. When are we going to see this?

**Hon. Deborah Matthews:** I'm a bit confused by your line of questioning. You just told me that it's not going to be helpful for people with diabetes, and then you're saying people with diabetes are waiting for the—

**Mr. Michael Harris:** It is helpful, Minister.

**Hon. Deborah Matthews:** I'm just confused by the argument that you're making.

**Mr. Michael Harris:** Minister, this registry will be extremely helpful, but it's not rolled out yet. When is it coming? Tell Ontarians who have diabetes today when the rollout will happen. What is the date?

**Hon. Deborah Matthews:** What I can tell you is that Infrastructure Ontario and eHealth Ontario are very focused on this diabetes registry becoming operational.

**Mr. Michael Harris:** But why isn't your Ministry of Health focused on this?

**Hon. Deborah Matthews:** Well, I can tell you that we are. It is the responsibility of eHealth Ontario and Infrastructure Ontario to deliver the contract. I am very, very

disappointed that we do not have this registry up and running right now.

**Mr. Michael Harris:** Well, who's responsible? Ultimately, you're responsible for this, though, Minister.

**Hon. Deborah Matthews:** I can tell you that your suggestions that money has been wasted are false. No money will be spent on this project until we have a substantially completed product.

**Mr. Michael Harris:** So you're telling me that no taxpayer dollars have been spent, to date, on anything to do with the diabetes registry at all?

**Hon. Deborah Matthews:** That is correct.

**Mr. Michael Harris:** So you're saying there haven't been funds allocated through eHealth for the implementation of this diabetes registry at all?

**Hon. Deborah Matthews:** The contract with CGI is clear: They get paid when and if they deliver the product. There will be no money flowing to CGI until they have met their contractual obligations.

**Mr. Michael Harris:** Right, but I'm assuming and I'm confident that money has been spent through the bureaucracy, through eHealth, through the ministry, to develop the specification—all kinds of things—and Ontarians still don't have this much-needed registry that will help folks with diabetes.

**The Chair (Mr. Michael Prue):** And with that, I have to cut you off. The 20 minutes is up.

**Mr. Michael Harris:** All right.

**The Chair (Mr. Michael Prue):** We're going to break now for lunch. You're going to get an extra three minutes because of the timing here. Please be back at 1 o'clock. Lunch is available for members of the committee and staff in committee room 1. We stand recessed until 1 o'clock.

*The committee recessed from 1227 to 1305.*

**The Chair (Mr. Michael Prue):** I call the meeting back to order. The time rotation is now going to the NDP. Ms. Gélinas.

**M<sup>me</sup> France Gélinas:** I would now like to ask a few questions about home care. The first one has to do with competitive bidding and the rumours from the field that the association of CCACs is working on a new policy for new, flexible contracts starting this fall. First, where are we with competitive bidding, and is the way we award contracts going to change, stay the same etc.?

**Hon. Deborah Matthews:** I think we all agree that home care is a part of our health care system where we really do need to focus significant attention. We are working very hard to drive improved quality in all parts of our health care system, and that includes home care. As you can appreciate, when people are receiving home care they are unsupervised. Some of the checks and balances in other settings are not there in home care. So driving quality, how do we improve quality? How do we measure quality? Our focus very much has been on ensuring that home care that is provided is the highest possible quality of care.

We put a moratorium on competitive bidding because we wanted to get the quality piece right before we went

out to competitive bidding, because quality is every bit as important if not more important than price. In fact, without high quality, we don't care what the price is. So that work is under way.

The Ontario Association of CCACs is developing a sector-led strategy because the existing contracts do roll over this fall. What are we going to do as those contracts wind up to ensure continued care? The Ontario Association of CCACs is working with their partners in that sector to give us that advice so that we can ensure continuity of care in the home care sector and the highest possible quality of care.

**M<sup>me</sup> France Gélinas:** And when will a decision be made as to what kind of competitive bidding system we use going forward?

**Hon. Deborah Matthews:** We are not in a position to give you an answer to that. There has been no decision made about lifting that moratorium. As I say, until I can be assured that we know how to measure quality and we have a way to ensure that home care is being delivered at the highest possible quality, I'm not interested in moving forward on competitive bidding.

**M<sup>me</sup> France Gélinas:** Okay. Then can we have an update as to the number of contracts that CCACs have? I would like it broken down as to the number of contracts for-profit and not-for-profit, the pure numbers, and then the percentage of dollar amounts. So let's say there's 100 contracts to the for-profit and 200 to the not-for-profit, but money-wise, it's not necessarily 30%-60%—so an idea as to how many there are in these categories and how much money they represent.

**Hon. Deborah Matthews:** So you want a sense of the mix of for-profit and not-for-profit in the home care sector.

**M<sup>me</sup> France Gélinas:** In the home care sector, correct.

**Hon. Deborah Matthews:** Let's see what we can get you on that.

**M<sup>me</sup> France Gélinas:** Okay, thank you.

Does the province know about the different wait-lists for the 14 CCACs and for different home care services that they provide?

1310

**Hon. Deborah Matthews:** The LHINs, obviously, pay very close attention to that. The CCACs are accountable to the LHINs. I think what you're asking about is the variation from one LHIN to another LHIN in terms of the care that's provided.

**M<sup>me</sup> France Gélinas:** As well as the totals. I wouldn't mind knowing how many people are on a wait-list for home care, let's say personal services or home care for having whatever amount of service. I would certainly like it broken down as much as possible, but also knowing it province-wide—that would be a telling number.

**Hon. Deborah Matthews:** We'll get you that information, if we can. I'm not sure what's available and in what format, but we'll dig into that one.

But just as we're changing how we fund hospitals to an activity-based, person-centred funding model, we are going to be doing the same in home care. What we will

see going forward, as we implement this, is that CCACs will be funded on the basis of how much care they provide. I think this is an important rebalancing again so that we have common, or as close to common as we can, services provided by CCACs across the province.

**M<sup>me</sup> France Gélinas:** All right. In that line of thought, then, I would like to know—different CCACs seem to have different maximum hours of care. I don't know why but it seems to be that way. I would be interested in knowing, what are the maximums that exist? What percentage of their clients actually do get the maximum? And what are the average hours of care that their clients get, and what percentage of their clients receive the average? Is this something that you guys know?

**Mr. Saïd Rafi:** Well, I'm not sure that they track it based on averages, although that's a computation, of course. The unique nature of the client would be a determination made by that case manager. It's really, I think, going to be difficult to foresee a set-up that says, LHIN by LHIN, the average amount of service provided.

We could provide that computation. I worry about what it tells us and what it might mask or not inform as to what's the grid or the spectrum of services needed and would that variation lead to some positive or false conclusions, by LHIN.

**Hon. Deborah Matthews:** The other part that I think is important in this conversation is that we are moving forward with implementation of programs like Home First, where people get very extensive and intensive home care supports when they leave hospital. In fact, there are no service maximums. Some people receive 24-7 care as they transition out of hospital and to home. As we look to home care to help us get people out of hospital sooner and keep them out of long-term care, we might see some distortions in those averages, because some LHINs are moving forward more aggressively on Home First.

We'll get you the information that we can, but I would be very careful about interpreting any of those results, because home care—and this is a very good thing—is really changing how it delivers care. It is being taken much more seriously now, I would say, than it has been in the past. It is a very important part of our health care system and we have very high expectations of people providing care in the home.

**M<sup>me</sup> France Gélinas:** Okay.

**Mr. Saïd Rafi:** If I could just add, some of the recent initiatives will also provide that immediate support within 72 hours. Now, whether that gets counted as a home care service—if it's a rapid-response nurse, for example—is arguable because some LHINs may treat that differently and may log it differently. That's why I'm just concerned that the data may belie certain actions that are actually taking place—because your home care needs could diminish as a result.

**M<sup>me</sup> France Gélinas:** I think you're going into the direction that I wanted you to go anyway. That shows that of the 14 CCACs, they have different series of programs for different people, for different occasions, and all

of those are different from one CCAC to the next. The example that the minister just gave: that if you get discharged and need 24-hour care, you would get this in some of the CCACs; in others, even if you do need 24-hour care, the maximum they will ever give you is 12.

What I'm getting at is pretty much in line with the answer you've just given me, that it varies so much from one CCAC to the next, from one combination—a client coming out of a hospital in London with the exact same needs as a client coming out of the hospital in Sudbury could end up with completely different access to home care because they happen to be in one CCAC rather than the next, because one CCAC has these sorts of rules and these sorts of limits.

What I'm interested in is, do you guys keep track as to what are the different programs with the maximum hours of care from the 14 different LHINs? Because they vary just as much as you've explained to me right now.

**Mr. Saäd Rafi:** I would say in addition, though, that the core programs would be the same; how they're interpreted and applied to patients and clients will vary for sure.

There may be caregiver support with that client in London versus in North Bay etc. You know better than I do that those things have a demonstrable impact on what the case manager feels is the level of service to individual need.

As we said earlier, we will try to get those service maximums and, perhaps, averages by LHINs for home care, if we have them—

**M<sup>me</sup> France Gélinas:** Or even by “service.” If you're part of Home First, here's your service maximum, here's your average. If you are known as chronic home care—you have been on home care for a long time—what are the maximums that you can have in your CCAC and what is the average that people in that category get? There are six, seven, sometimes eight different categories of maximums you can get, and those vary from CCAC to CCAC. The fact that you have five, six, seven or eight different categories also varies from CCAC to CCAC. I'd like to have a global picture of that.

**Hon. Deborah Matthews:** Part of the job description of Dr. Sinha, who's heading up our seniors care strategy, is to look at home care. I have one colleague who is blessed by having four different LHINs in her riding, four different CCACs, so she sees first-hand—

**M<sup>me</sup> France Gélinas:** You use “blessing” generously.

**Hon. Deborah Matthews:** Exactly, yes. She certainly has explained to me how there are different policies in different CCACs. I do believe that decision-making closest to the ground can be the best, but you need a constant province-wide standard as well. Trying to find that balance—we're moving more in that direction as we move to activity-based funding, for example.

We are absolutely determined to provide supports for people so they get care in the right place—home, whenever possible. That will mean more enhanced home care for some. This is very much a work in progress right now.

**M<sup>me</sup> France Gélinas:** Even if you date it, as of that date, I would be happy with having that kind of information.

My last question on home care is, what is the total home care operating fund coming from the province for home care? I was wondering if you could quote the last three fiscal years, just so that we can. If there was growth in funding, which we all know there was, if you could identify them also, as in number of dollars.

**Hon. Deborah Matthews:** Funding for CCACs in 2003-04?

**M<sup>me</sup> France Gélinas:** Not for CCACs, for home care.

**Hon. Deborah Matthews:** For home care alone?

**M<sup>me</sup> France Gélinas:** Yes.

**Hon. Deborah Matthews:** Would you be interested in CCACs? Because the bulk of that is home care, right?

**M<sup>me</sup> France Gélinas:** I already have the CCAC numbers. They're easy to come by. It's the home care dollars of this that I'm interested in.

**Hon. Deborah Matthews:** Okay. Let's see what we can get for you on that.

**M<sup>me</sup> France Gélinas:** Sounds good.

I have a few odds and ends. How many minutes, Mr. Chair?

*Interjection.*

**M<sup>me</sup> France Gélinas:** Fifteen? Oh, thank you.

**The Chair (Mr. Michael Prue):** No, no, about six or seven.

**M<sup>me</sup> France Gélinas:** Okay. I just thought I would throw that out there.

*Interjection.*

**M<sup>me</sup> France Gélinas:** Just checking, yes.

You made an announcement for birth centres. I just wanted to know what is the process, how far along, and when can we see a next step?

**1320**

**Hon. Deborah Matthews:** We put out a call for midwife practice groups to come forward with proposals on stand-alone birth centres in their communities.

Are those tenders still open, that call for proposals?

**Mr. Saäd Rafi:** Yes, I'm familiar with the call for proposals. I'm trying to recall if it's closed and staff are reviewing. The procurement process will be a two- to three-month process at the very least, and then we'll move to undertake a review for the two centres. There's quite a detailed set of criteria for midwives and birth centre candidates to meet.

**M<sup>me</sup> France Gélinas:** All right. So if you give me an expandable timeline—the procurement process, another three months, let's say, and then what are we looking at before you have made a selection and start working with that particular practice to put a birth centre in place?

**Mr. Saäd Rafi:** The selection shouldn't take more than a few weeks. Then it will be a function of how fast those centres can get incorporated. They may have partners with them, all not-for-profit models.

So it's really hard to say, but if our family health team and NPLC experience is an indicator, it may mean, let's say, if the RFP closed next September, a month—

**Hon. Deborah Matthews:** The RFP does close in September, I've been notified.

**Mr. Saäd Rafi:** I was just going from memory. Thank you.

So it could easily be early into 2013-14 when there's a physical location. But that's a pretty gross timeline.

**M<sup>me</sup> France Gélinas:** I understand. But by September, the RFP procurement process would have been concluded. You give yourself a month to make a decision, and then you would start working with a particular midwife practice, or a few.

**Mr. Saäd Rafi:** Yes. I can't recall if the RFP calls for the proponents to have a location or whether we then have to work with them for them to get a location. As we can all imagine, sometimes that can take several months. I just don't recall all the criteria in the RFP.

**M<sup>me</sup> France Gélinas:** As those become clearer, I certainly would like some information on this as to how the process is—if you have some specific dates that are public information, if you could share that.

**Hon. Deborah Matthews:** What I can tell you is that there are many midwife practice groups that are very excited about the potential, and you probably have heard that as well.

**M<sup>me</sup> France Gélinas:** Yes, I have.

**Hon. Deborah Matthews:** Yes.

**M<sup>me</sup> France Gélinas:** The next one has to do with smoke-free Ontario and just to see if the government has any interest in closing up the loophole about flavoured tobacco—Ontario did pass a bill and there was a loophole that was left behind—and if there's any interest in moving in that direction.

**Hon. Deborah Matthews:** I want to thank you for bringing that issue forward, and it is one that we are giving serious consideration to.

**M<sup>me</sup> France Gélinas:** Oh, good. And do we have—

**Hon. Deborah Matthews:** You have good ideas.

**M<sup>me</sup> France Gélinas:** Do we have any idea as to when those good ideas could be acted upon?

**Hon. Deborah Matthews:** No.

**M<sup>me</sup> France Gélinas:** No. All right. Well, you can't blame me for trying.

Same with talking about health promotion: We don't have a Ministry of Health Promotion anymore. It has been transferred. How can I know that all of the programs that were under the Ministry of Health Promotion are still there and existing? Do they still have funding? Has the funding changed? How do we follow those?

**Hon. Deborah Matthews:** Just to be clear, the sport part of health promotion and sport did not come to the Ministry of Health. It went elsewhere. But, yes, the programs remain. Maybe you could speak to—

**Mr. Saäd Rafi:** They do, and the funding has remained intact from the previous fiscal year. In fact, that funding is already, of course, flowing to transfer payment partners.

There are a couple of ways of tracking that. One would be through public accounts—the published. In 2012-13, I believe, in our printed estimates—

**Interjection:** Vote 1414.

**Mr. Saäd Rafi:** —we have a vote and item in the printed estimates that shows the health promotion spending allocation.

**M<sup>me</sup> France Gélinas:** Okay, so vote 1414, I could see the aggregate, but you're telling me that whatever amounts of money that were associated with all of those programs and services that were transferred to health are still existent and are still being funded?

**Mr. Saäd Rafi:** As far as I can recall. I'm searching my mind quickly as to whether there was any exception in that regard or if something was deemed more sport than health promotion, but I don't believe so.

**M<sup>me</sup> France Gélinas:** Okay. Next question—those ones are all disconnected. The next question has to do with chronic pain management. I've tabled a number of order paper questions on that issue, but given that you are both there, is there anybody presently working on a chronic pain management strategy? Are there any studies that are presently being reviewed? Is there hope for action? Anything you can share?

**Hon. Deborah Matthews:** What I can tell you is that out of our narcotics working group, the narcotics group that we pulled together, that was an issue that was very, very clearly articulated—that while we want to do everything we can to prevent illicit use of prescription narcotics, we needed to be there for people who have a legitimate need for pain relief.

I can tell you that I have had conversations with people in that world of chronic pain, both providers and patients. I think we have an opportunity to do significantly better when it comes to making sure that people with chronic pain get access to the help that they need. This is an area where there is an opportunity to do better.

**The Chair (Mr. Michael Prue):** I'm going to stop everybody right there. It is now the turn of the government. Mr. Dhillon.

**Mr. Vic Dhillon:** I want to speak a little bit about the OMA negotiations. It appears that the OMA is refusing to assist with helping the government with the economic situation that we're in, but when I speak to doctors in the community, they're happy with what the government is proposing. Could you tell us what the current status of those negotiations is?

**Hon. Deborah Matthews:** Absolutely. You'll remember from that pie chart on the slide deck that was handed out that a significant amount of the money we spend—in fact, it works out to 10 cents of every tax dollar—does go to physician compensation. We have made the strategic decision to hold constant to protect the gains we've made when it comes to physician compensation, but to work within that envelope to find the money to fund the population as it grows and as it ages.

I think in fairness to the OMA, they did come to the table with a fee freeze. That was terrific, but not enough to get us to where we wanted to go.

We proposed a number of fee code changes that reflected a few things. One was the small number of specialties where technology has significantly improved

productivity. It means one doctor can see a lot more patients now than they were able to before. We think those fees should come down to reflect that ability for one doctor to see more patients in the same period of time.

We've got technology-based changes, we've got evidence-based changes. There are some procedures that simply don't improve outcomes for patients. We don't want to pay for those any more. We'd rather spend that money on procedures that do improve patient outcomes.

We proposed a list of changes to the OMA on our first day of negotiations. Unfortunately, that did not spark the kind of debate within the medical community that I hoped it would. I had hoped that the OMA would go to its members and say, "Here's what the government's proposing. What do you think? What are the consequences? What are the unintended consequences?" That debate amongst the doctors did not happen, so we were forced—when the OMA left the table and made no indication of wanting to engage in that constructive problem-solving exercise, we did move forward on some changes. Since then, the OMA continues to refuse to come to the table and continue the conversations, but some doctors have offered to give us advice on how we could actually achieve the same savings going at it in a different way, and we welcomed that. That was actually what we had hoped would be happening through a negotiation process.

**1330**

At this point, we continue to hope that the OMA will come back to the table. There is certainly a significant expenditure on advertising that they're making, and, as you know, they're taking us to court.

We really do believe that the vast majority of doctors want to do what's right for their patients; that they acknowledge that they've been well paid. The average doctor has seen an increase in their billings of 75% in just eight years. By any measure, that's a significant increase.

We had a problem before. Ontario doctors were underpaid, and they were leaving the province. So we did have to increase compensation to doctors.

But at this stage, the right thing to do for all patients is to focus any additional new dollars we have on things that will really make life better for patients, and that is things like community care and home care.

**Mr. Vic Dhillon:** Thank you, Minister. I can personally attest to the fact—before this government took office in 2003, doctors and other medical professionals were leaving for the US because of the compensation issue, and now I've heard of examples where doctors are coming back. So that's a really positive step that we took.

Could you tell us how many more doctors Ontario has since this government took office and how the ministry is going about with the supply and distribution of doctors in Ontario?

**Hon. Deborah Matthews:** We have increased the number of doctors practising in this province by 3,400—3,400 more doctors. That is a remarkable improvement in a very short period of time, given how long it takes to train a doctor. We've been able to achieve that through a

number of ways. One is, increasing the number of international medical graduates. We've almost doubled the number, maybe more than doubled it. I think we're at 200 now; I think it was 91 before, if my memory serves me correctly. So we've got more international medical graduates getting trained here. More doctors are staying here. More doctors are coming here from other jurisdictions.

And of course, we've expanded our medical schools. We've created one brand new school in the north, and I have to tell you that that is having exactly the desired outcomes. It is attracting people from the north. They're training in the north, and they're staying in the north. That was an important part of our overall strategy to improve access to care and provide more equitable access to care.

So 3,400 more doctors are working today than when we took office.

**Mr. Vic Dhillon:** Thank you. I'm going to pass it on to Mr. McNeely.

**Mr. Phil McNeely:** Thank you. Minister, how will you plan to achieve the goals for increased access to health care, as set out in the action plan for health care in Ontario?

**Hon. Deborah Matthews:** There are many components to that action plan. I went through some of them in my earlier statements, but to recap, we are continuing to increase the number of doctors working in Ontario. We've also got more nurses, more allied health professionals working at their full scope of practice. For example, if pharmacists are granted the ability to provide immunization, that increases access to care for people.

We know, especially when you think of our seniors, that they may well be getting access to lots of care, but it's not coordinated care. So they have appointments with various specialists, but there's no one actually coordinating that care. It may be that they are seeing too many doctors and not getting that coordinated care. That's part of what we see as the role of primary care providers. We want to give those primary care providers—and having access, electronically, to those records will be part of that, where those primary care doctors are responsible not just for the primary care they receive, but for all their health care needs.

There's a lot of work under way in the action plan. We can achieve those results through the tools that government has. We've got some funding levers so we can fund hospitals for procedures not just based on global budgets. We've got the ability to shift growth in funding to certain parts of our health care system. So, as we shift from increasing physician compensation to increasing home care, that will drive that change.

There are a number of levers at our disposal, and we are using them all, but at the end of the day, it's our health care providers, it's our front-line providers, who have been wonderful partners to date and are excited, I think, about the changes that are coming. There are changes; it does mean they might have to do things a bit

differently, but they know that it will, in the end, provide better care for their patients.

**Mr. Phil McNeely:** The reform is well under way now. I think family health teams are something that I really look forward to, and the nurse practitioners, especially those practices—I think they've all been successful, but I think that really was an excellent move and is one that's proving very successful.

You showed the demographics this morning and you've spoken about the programs for seniors, but there's so much that has to be done there because the old method of 411 and "Take this senior off my hands. I can't provide for them anymore"—which was happening. Early contact with those seniors now is very important, and that's what you're doing.

Looking at what 2036 is going to bring—it's a doubling—how effective is this going to be of the transfer of more care to aging at home and to seniors?

**Hon. Deborah Matthews:** I don't think we have a choice. I think that if we value universal health care, we simply must change the way we deliver health care to reflect the needs of the population. We need to make changes now to meet today's demand, but we really need to accelerate change in order to meet tomorrow's demand.

As I say, I think there's a very strong argument to be made that it's not that we're not spending enough on some of those people with high health care needs, we're just not spending in the right places. If we're spending money on keeping someone in the hospital when that's not what they need, that's a waste of money. It's also not the highest-quality care for them. They'd much rather be home, supported by supports at home. Similarly, we know that about 37% of people going into long-term care don't really need that intensity of supports available in long-term care.

You know, I looked at Denmark as an example of a country that, back in the 1980s, made a decision not to build any more long-term-care beds—zero more—and they have an aging population too. But what they have done is, instead of spending money in long-term care, they have invested in things like supportive housing. I'm thinking of a place in Sudbury I visited there that has a range of supportive housing. The place is a vibrant, happy place, Finlandia—Finlandia in Sudbury?

*Interjection.*

**Hon. Deborah Matthews:** Yes, that kind of supportive housing for people who need a little more help, who can't stay home without supports, but sure don't need the intense support in long-term care.

1340

The other thing that I see in the future is us shifting our approach from people needing to move to long-term care to us providing care in the long term. People who have chronic conditions who need help now, sometimes their needs are more intense than at other times. I see a bright future for perhaps long-term-care homes having some beds where people can come in, get restored back to health and then go back home.

I think there's lots of innovation, but at the root of it is, how much care does a person need? Let's provide all that care, but let's not provide more care than they need and let's provide it in a proactive way so that, instead of having a short wait time for hip replacement surgery, we actually prevent them from needing that in the first place.

**Mr. Phil McNeely:** That ad on the television, "Homeowners helping homeowners"—I think seniors helping seniors is a positive way through the organizations that seniors have etc. I am very pleased that we are going in that direction.

How will the health system funding reform be phased in? You've already gone through part of that, but if you could just extend on that.

**Hon. Deborah Matthews:** We're starting with hospitals and, over three years, we are moving to a funding formula that reflects the services they provide in those hospitals and the needs of their community. Hospitals are under way. Hospitals know what their allocations are; they know what's coming.

We are moving to activity-based payment. If you do 100 hip replacements, we'll pay you for 100 hip replacements. I think this year, we're starting with four procedures that we're doing on an activity-based payment model. Over the next three years I think we get to 31 procedures, so that hospital budgets will slowly—well, over three years; that's not so slowly, maybe—reflect their activities. I know that's the right way to go.

We will also be bringing forward a similar activity-based funding model for home care. Long-term care is really there now because they are paid for the number of people and the degree of support people require in those long-term-care homes.

**Mr. Phil McNeely:** But the transformation for hospitals, then: How is that being received by the administration? Because it seems to me, from a business perspective, that's the proper direction to go. How is it being received by the hospitals?

**Hon. Deborah Matthews:** I can tell you, when this idea was first floated, there was strong support for it in principle. Then of course, as people started to see the impact on their own institution, maybe for some, that support wasn't quite as enthusiastic as it had been. But overwhelmingly—and I have to give a shout-out to Ontario hospitals. They understand why their budgets are being adjusted. They accept that. They are working to become more efficient as organizations. I have to tell you that I expected more hospitals to be unhappy with the results, but I have been very proud of our hospitals because, virtually without exception, they understand why their budgets are what they are and are working within those budgets to provide the best possible care. They understand that this is part of a really important system change.

In fact, the Ontario Hospital Association has been a leader in driving system change. They were the ones that argued that if you've got more money to spend, spend it in the community sector. They're aware that for many of the challenges they face, they have the problem, but the

solution is outside their hospital walls. So they've been very good partners.

**Mr. Phil McNeely:** It's good to see that there will be an incentive to keeping the operating rooms operating in the summertime, not closing them down because of budget constraints. The incentive will be to do more and get paid more, so I think that's great.

How much more time do I have, Chair?

**The Chair (Mr. Michael Prue):** Probably about two minutes.

**Mr. Phil McNeely:** The birthing centres were covered by the member from the third party, but I have a group in Ottawa–Orléans who are very interested in how that is going. This is an excellent start. We should, within a year, have up in the province—is it two or three?

**Hon. Deborah Matthews:** Two. We're starting with two.

**Mr. Phil McNeely:** How do you see it unfolding beyond the two opening?

**Hon. Deborah Matthews:** We do want to get two up and running and see how that goes, but I think there is significant appetite for this. We want to take procedures out of hospitals if they don't need to be in hospitals. If they can be performed safely, at a high quality, at a lower cost, in a way that the people prefer to be cared for, then we want to support that.

I can tell you, I have seen first-hand in my own family the excitement people have with the idea of there being a third option. Currently, women—families—have a choice of at home or in the hospital. I think a lot of expectant families would welcome the opportunity to have a midwife-led birthing centre as a place where they could have their child.

**Mr. Phil McNeely:** There's seven of us; we were all born at home.

**Hon. Deborah Matthews:** You were born at home?

**Mr. Phil McNeely:** Yes, and my sister's family were all with a midwife, in the rural community. I think it's the right direction to be going. Thank you.

**Hon. Deborah Matthews:** Thank you.

**The Chair (Mr. Michael Prue):** Just before we go on to the Conservatives, just to let the members know, there are two additional rounds left, if I've done my math right. Then the last portion will be apportioned equally. So, two full rounds left each.

To the Conservatives.

**Mr. Rick Nicholls:** To the Minister: I'm going to read a quote from the Auditor General, Jim McCarter, from CBC on October 9, 2009. He said this—

**Hon. Deborah Matthews:** From 2009?

**Mr. Rick Nicholls:** Yes, ma'am.

**Hon. Deborah Matthews:** Okay.

**Mr. Rick Nicholls:** He said, "When you have a lack of oversight, that's a lack of appropriate management.... When you get a lack of oversight, you get broken rules."

From my training and consulting days, one of the things I was a strong advocate in, as I was doing a lot of leadership development—and I actually spoke to the Canadian embassy at the United Nations a couple of

times regarding this—we used to say that when it comes to performance, make sure that if you have to take someone aside, you're critical of the performance, not the performer. There's a big difference there, and I'm sure you appreciate that.

What I'm suggesting here is that I'm going to be commenting on performance of the Ministry of Health, so I just don't want you to take it personally. However, you are the minister responsible for the performance of your ministry, and you are the one that must hold people accountable. So, on that note, I'd like to ask you a few more questions regarding the eHealth scandal that we've been discussing already today.

You know that the eHealth scandal—and I stress, the original eHealth scandal—as we're talking about this, I believe that we're witnessing here today the opening of what I would call a salvo of eHealth scandal 2.0, and maybe even 3.0 at this point, because it was caused largely by exorbitant spending on consultants. I remember the Toronto Star article detailing that one consultant charged \$30,000 for 78 hours of work. Now, quick math would say that's almost \$400 an hour. I have to confess, Minister, that's a pretty good gig, if I do say so myself.

But in response to the first scandal, rules were changed about the use of consultants. Is that correct?

**Hon. Deborah Matthews:** That is correct, yes.

**Mr. Rick Nicholls:** Okay, thank you. But again, Minister, we have it on good authority that eHealth's dependence on consultants has not gotten better; in fact, it has gotten worse.

Are you familiar with the term "fixed-fee contractors"?

**Hon. Deborah Matthews:** No, I can't say that I am.

**Mr. Rick Nicholls:** Oh. Okay. Well, I understand that eHealth has deliberately moved to hiring fixed-fee contractors in an effort to skirt the rules governing consultants. Are you aware of that?

**Hon. Deborah Matthews:** What I can tell you, when it comes to consultants at eHealth Ontario, is that there has been a significant reduction. In April 2009, there were 394 consultants at eHealth Ontario. As of March 31, 2011, there were 122; March 31, 2012, we're down to 66; and then as of May 31, 2012, we're down to 53—so from 394 in April 2009 to 53 at the end of May. I think we've made significant progress in reducing the use of consultants at eHealth Ontario.

1350

**Mr. Rick Nicholls:** I see. Well, we'll talk, maybe, a little bit more about "fixed-fee contractors," which may be a way of getting around that issue of consultants. I would agree that, utilizing the term, you've dropped it down significantly. We'll talk more about that.

As you know, you and your friends at Ornge got into a lot of hot water over Ornge's decision to pay for expensive advanced degrees for its employees.

Ms. Alice Keung, a senior executive at eHealth is presently having her Ph.D. paid for by taxpayers, including her travel expenses back and forth between Toronto and Ottawa.

Just a side note, Minister: I know you have your Ph.D. and I truly respect that. Did you get your travel expenses paid for when you were going after your Ph.D.?

**Hon. Deborah Matthews:** No.

**Mr. Rick Nicholls:** Point taken. I wish we all could have.

Do you care to explain—

*Interjection.*

**Mr. Rick Nicholls:** My colleague wishes that as well. But on a serious note, could you explain to us how this could be the case; how, in fact, she's getting her Ph.D. paid for by taxpayers, including her travel expenses back and forth between Toronto and Ottawa? Can you explain that, please?

**Hon. Deborah Matthews:** No, I can't; no, I can't. What I can tell you is that—

**Mr. Rick Nicholls:** She is getting it paid for but you can't explain why she's getting it paid for.

**Hon. Deborah Matthews:** What I can tell you is there has been a remarkable change of direction at eHealth Ontario, a complete change of leadership at eHealth Ontario—I'm sorry—at Ornge.

**Mr. Rick Nicholls:** Ornge.

**Hon. Deborah Matthews:** Actually at both—but at Ornge.

**Mr. Rick Nicholls:** Did you know, though, that her tuition was being paid for?

**Hon. Deborah Matthews:** That is not something that I was aware of, that there was a Ph.D. being covered. I certainly did know that certain individuals had MBAs covered, completely not reported to ministry officials. We know that at Ornge there was a culture of real resistance to opening information. The Auditor General himself said that he has been Auditor General for nine years, he has done about 150 value-for-money audits and that he has never seen anything like the culture of secrecy—those aren't his words, but he found it more difficult to get information from Ornge than he has ever seen in any of his other 150 audits.

We had the same problem at the ministry. We did not get information that we asked for, and information that we got was not always accurate, so the decision—

**Mr. Rick Nicholls:** Does that same culture exist at eHealth?

**Hon. Deborah Matthews:** At eHealth today?

**Mr. Rick Nicholls:** Yes, ma'am.

**Hon. Deborah Matthews:** No. I think we have a very good relationship with eHealth Ontario. I think they are good partners with us.

**Mr. Rick Nicholls:** You made a comment earlier that significant changes have been made in the management at Ornge, as well as at eHealth. I guess one of the things that kind of jumps to mind is: "too little, too late." There's an old saying that once the horse is out of the barn, it's too late. Our concern is—recognizing what you're doing now, however, we're looking at perhaps the mismanagement of funds prior to, which has constituted you having to make these significant changes in the leadership not only at eHealth but also at Ornge.

I guess our concern is that taxpayers' monies have, in fact, gone down the drain. Of course, one of the concerns that I have about that is, how many more cuts to the Ministry of Health's budget will occur at the expense of the taxpayer because, in fact, of the mismanagement of other funds which could have been used more appropriately and more suitably had those scandals not taken place?

**Hon. Deborah Matthews:** I can tell you, first of all, we're not cutting health care budgets. They are not growing at the rate that they used to, but we're not cutting budgets.

I can tell you that my determination to get best value for every dollar we spend in health care could not be stronger. My ministry officials feel exactly the same way. We will always be vigilant, and any time there is a situation that arises where those leaders who have been entrusted with two responsibilities—one, to deliver care, and the second, to manage money appropriately—when ever there is a failure of leadership, we will take the appropriate actions.

Overwhelmingly, health care leadership in Ontario is committed to providing better patient care and providing good value for those health care dollars, but whenever a situation arises—and Ornge is one of those situations, where the board of directors at Ornge, the CEO at Ornge, lost sight of their responsibility to the public—I will take action. I make no apologies for that, no apologies whatsoever, for taking that appropriate action on those rare occasions when it does occur.

**Mr. Rick Nicholls:** Patient care is critical, and I agree with that. The concern that we have, of course, has been the mismanagement of funding. Someone has to take the bullet, so to speak, for that mismanagement of funds.

You say that you're not cutting costs in health care. Well, then we've lost all this other money. In other words, I'm looking at what I would call ROI, in business terms: your return on investment. What are you getting for all the money that so far has been wasted through Ornge scandals—\$750 million—and the eHealth scandal, which is maybe over \$2 billion in total? Not a whole lot of ROI on that as of yet. You're not cutting health—

**Hon. Deborah Matthews:** Can I just—I'm sorry.

**Mr. Rick Nicholls:** Certainly.

**Hon. Deborah Matthews:** I have to stop you there.

**Mr. Rick Nicholls:** Okay.

**Hon. Deborah Matthews:** What you're doing is—you have mistaken something important. We spend money on Ornge. Ornge provides care; it transports close to 20,000 patients a year.

**Mr. Rick Nicholls:** Oh, I understand that.

**Hon. Deborah Matthews:** So you're telling me that the money we pay Ornge is wasted?

**Mr. Rick Nicholls:** No, no—

**Hon. Deborah Matthews:** I completely disagree with you. Every one of those patients—

**Mr. Rob Leone:** That's not what he said.

**Mr. Rick Nicholls:** That's not what I said.

**Hon. Deborah Matthews:** —and every one of those patients' families would disagree with you as well. We

invest in Ornge; they provide a service. Were there areas where they were spending money unnecessarily? Absolutely. That's why they're all gone. That's why they don't work there anymore. But for you to total all the money spent on Ornge and just forget about the fact that there have been 100,000 patients transferred in that period of time, I think, is not quite representing reality.

**Mr. Rick Nicholls:** And you're right. My reference, though, Minister, was to the \$750 million which has been identified as—

**Hon. Deborah Matthews:** What are you claiming as \$750 million?

**Mr. Rick Nicholls:** Everything that has been involved with the Ornge scandal.

**Hon. Deborah Matthews:** That is completely erroneous. That is the total amount of money that has been spent on Ornge, including transfers for all those patients. The Auditor General was asked how much money we were talking about when it came to Ornge. He said maybe \$10 million. So it's a big leap from \$10 million to \$750 million.

**Mr. Rick Nicholls:** I'll get back to that.

**Hon. Deborah Matthews:** The Auditor General was very clear on this. We'll provide you with that quote.

**Mr. Rick Nicholls:** Thank you. Minister, are you worried about what the committee will learn when you submit all the documentation that we requested last week? I understand it's very likely that a few senior executives at eHealth are going to have some explaining to do.

**Hon. Deborah Matthews:** Are we back to eHealth now?

**Mr. Rick Nicholls:** Yes, ma'am. Yes, we are.

**Hon. Deborah Matthews:** We're back at eHealth. Okay. So you've requested some information. We'll get that information to you.

I believe in transparency. I believe that transparency is an important part of government. I think that sunshine is the best disinfectant. That's why we opened hospitals up to FOI, because we do believe that the public has a right to that information. That's why hospitals are now posting the contracts for their CEOs online. I think that the more light that can be brought to an issue when it's public dollars, the better.

**Mr. Rick Nicholls:** So if I understand you correctly, you said you believe in open transparency, which is a wonderful thing, and yet you wouldn't allow us to have a select committee back when a lot of this first came to light, way back in late January, early February.

**Hon. Deborah Matthews:** As I understand it, the public accounts committee has met for 53 hours. I believe 47 witnesses have come forward. There is a lot of scrutiny under Ornge.

**Mr. Rick Nicholls:** No, I recognize that. It was a select committee.

**Hon. Deborah Matthews:** Well, I think the public accounts committee is doing a very thorough job. There is significant oversight at Ornge. The Auditor General, the forensic audit team, the OPP, the standing committee—

**Mr. Rick Nicholls:** I couldn't let it go when you mentioned, "complete transparency." I thought I would throw in select committee.

**Hon. Deborah Matthews:** I think there's significant oversight at Ornge.

**Mr. Rick Nicholls:** Let me bounce this back to eHealth for a moment, okay? A little while ago, eHealth made headlines when it approved significant bonus packages for its employees. At the 11th hour you intervened and eHealth backed down, but according to eHealth insiders, you and ADM David Hallett approved these raises. Is that true?

**Hon. Deborah Matthews:** What is true is that—

**Mr. Rick Nicholls:** Raises were approved and then you cut back?

**Hon. Deborah Matthews:** —I was concerned about bonuses being paid to eHealth. I asked the board of eHealth to take another look at that bonus package, and they made the decision that there would not be bonuses paid that year.

**Mr. Rick Nicholls:** Did you sign off on the raises before they became a political liability?

**Hon. Deborah Matthews:** I would have to refer back. What I can tell you is I welcomed the decision of the board of eHealth Ontario to forgo bonuses that year.

**Mr. Rick Nicholls:** Is it yes or no, then, before it became a political liability?

**Hon. Deborah Matthews:** What I'm saying is that I would have to go back and check.

**Mr. Rick Nicholls:** You don't recall the reason for your decision on that.

**Hon. Deborah Matthews:** This was a couple of years ago now. I would never want to give you information that I wasn't 100% certain about.

**Mr. Rick Nicholls:** Okay. Well, I appreciate that. I appreciate the transparency—at least the openness. Hopefully, transparency follows with that too, Minister.

To my colleagues, do we have anything else you'd like to add?

**Mr. Rob Leone:** Absolutely. Mr. Chair, I have a letter that I'd like to distribute to the committee—

**The Chair (Mr. Michael Prue):** Sure.

**Mr. Rob Leone:** —in the spirit of openness and transparency.

**Hon. Deborah Matthews:** I trust you're going to give me a minute to read this.

**Mr. Rob Leone:** Absolutely. Well, maybe I can speak without asking a question as you catch up to speed. I will highlight certain sections that I wish to point out as we do that.

One of the things that I think we've—

**Mr. Phil McNeely:** Point of order.

**The Chair (Mr. Michael Prue):** Before we accept this, I think the record should note that this appears to be an anonymous letter. Would you agree that that's what it is?

**Mr. Rob Leone:** That is correct.

**The Chair (Mr. Michael Prue):** By person or persons unknown.

*Interjection.*

**The Chair (Mr. Michael Prue):** All right.

A point of order?

**Mr. Phil McNeely:** The point of order was that we've just received this. As you point out, there's no signature on it. We'd like a short recess so we can read it before the minister is asked questions on it.

**The Chair (Mr. Michael Prue):** Is it the committee's agreement that there is a short recess? How much time do you have in mind? Ten minutes?

**Mr. Phil McNeely:** Possibly; 10 minutes at the most.

**The Chair (Mr. Michael Prue):** Okay. There will be a 10-minute recess so that all members may read this document.

*The committee recessed from 1403 to 1413.*

**The Chair (Mr. Michael Prue):** Okay, I call the meeting back to order again.

I don't know what the member wants to do with this. We don't usually accept anonymous letters in committee, but you have handed it out and everybody has read it.

**Mr. Rob Leone:** Thank you, Mr. Chair. We asked a number of questions today with respect to things that are going on in eHealth and in the Ministry of Health.

I want to go back, before we delve into some of the other issues before us, to page 2, paragraph 2, where it states that the Ph.D. that is being paid for—the salary of Ms. Keung is \$245,000 and change and that, as this letter claims, this Ph.D. is being paid for, including travel between Ottawa and her home.

Minister, we are in a period of austerity. My question to you is: Given that we are in this period of austerity, do you think it's a good thing for us to be paying for Ph.D.s for employees who make more than \$200,000?

**Hon. Deborah Matthews:** This is a bit unusual, an unsigned letter. There are many allegations and suggestions in this letter. I think what I would like to do is actually do a little bit of homework, a fact-check on some of these allegations.

What I can tell you, though, is that when it comes to the eHealth bonuses that we were talking about a moment ago, I did not have any prior knowledge, so I know that one part of this letter is factually incorrect. There was no correspondence between David Hallett and myself on this issue. I know that is false. Until I read it in the paper, I did not know that eHealth was proposing bonuses for their employees, and when I did become aware of that, I did talk to eHealth Ontario and asked them to reconsider that decision.

**Mr. Rob Leone:** Notwithstanding this example, which, of course, came from a whistle-blower, an anonymous source, in generality I'm asking, do you believe it would be acceptable in a period of austerity to be paying for the travel costs and for the degree, a Ph.D. in this case, of an employee who makes more than \$200,000?

**Hon. Deborah Matthews:** It's very difficult for me to comment on something that I do not have the context for.

I do know that the Ontario public service does have a program for employees in the OPS to upgrade education. Perhaps the deputy—maybe this isn't fair to ask him, but

perhaps he could share what we know about that program for OPS employees and we can get more information on that.

But I really can't respond to something where I just simply don't have the necessary context.

**Mr. Rob Leone:** Again, Minister, I'm just trying to get a sense of whether we could get an understanding of—

**The Chair (Mr. Michael Prue):** I'm going to have to cut you off. You have one more 20-minute time, so—

**Mr. Rob Leone:** Sure.

**Mr. Phil McNeely:** Point of order, Chair.

**The Chair (Mr. Michael Prue):** Point of order.

**Mr. Phil McNeely:** Could we have on the record here that this an unsigned, fact or fiction, letter?

**The Chair (Mr. Michael Prue):** I believe, as the Chair, I identified that immediately upon receipt.

**Mr. Phil McNeely:** Thank you.

**The Chair (Mr. Michael Prue):** It is part of the record, and it has been reiterated several times. It is not signed. We have no way of knowing who the author is.

Ms. Gélinas.

**M<sup>me</sup> France Gélinas:** As interesting as this letter is, I'm going to be talking about long-term care. I would like to know if I could get the number of paid hours in long-term care by nursing and personal care classifications and have this by the different homes: for-profit, not-for-profit nursing homes; municipal homes for the aged; charitable homes. This is a little chart that I ask for quite often, and it hasn't come as of late, so I figured today would be a good day to ask for it again. It's basically the hours paid for nursing and personal care, with the personal care classification broken down into RN, RPN, PSW, and then by classification of homes—and have this as to as recent information as you could give me.

**Hon. Deborah Matthews:** Just for clarification, this is a document you have received in the past?

**M<sup>me</sup> France Gélinas:** Yes. I've requested the same thing pretty well every year. I used to get it every three months; now I ask for it once a year.

**Hon. Deborah Matthews:** Okay. Ministry officials will know exactly what it is you're looking for.

**M<sup>me</sup> France Gélinas:** Yes, they will. They have done it before. Do you recognize this, Mr. Rafi?

**Mr. Saïd Rafi:** I believe so, yes.

**M<sup>me</sup> France Gélinas:** Yes, you have submitted those before.

That brings me to the next one. Would you ever consider putting that type of information either on a website or on someplace where it is accessible? I would love it to identify the specific homes, but even if you don't identify the specific homes, drill it down as much as possible so people can use it as a source of information.

1420

**Mr. Saïd Rafi:** I only hesitate because I'm not sure what—well, yes, subject to personal health information and so on, we would have to check with the homes themselves and what our MOUs say with the homes, through the LHINs, as well.

It sounds, on the face of it, that it's a reasonable request. But we do have for-profit publicly traded organizations, as you know, so I hesitate there, because I don't know what implications that has for them, if any.

Again, we'd need to check. It's a fairly specific request for the amount of nursing. I think you want the nursing and personal care hours for RN, RPN and PSW by home type.

**M<sup>me</sup> France Gélinas:** Correct. That's the way you usually—

**Mr. Saäd Rafi:** For all 600-and-some homes.

**Hon. Deborah Matthews:** For 630 homes.

**M<sup>me</sup> France Gélinas:** Yes. Usually you break it down into nursing homes for and not for profit, municipal homes for aged, and charitable homes. I have the "for" category, and then you put down RNs, RPNs etc.

**Mr. Saäd Rafi:** Right, okay, but it is aggregated by those categories.

**M<sup>me</sup> France Gélinas:** Yes, it is.

**Mr. Saäd Rafi:** Okay.

**M<sup>me</sup> France Gélinas:** If this could be made accessible online, that would be a step in the right direction, and if we can drill down a little bit further and have it by LHINs or have it by—it would be worthwhile information.

I get that information from you on a regular basis, and I do use it lots. I show it to people who come; I share it with people who have to make decisions about which home to select etc., so I thank you for this.

The next question has to do with the Casa Verde inquest. Has there been any new follow-up as to the coroner's recommendations following this tragedy? Is anybody following it up? Do you know if any more of the recommendations have been implemented since we talked about this last time, a year ago?

**Hon. Deborah Matthews:** I would like to get you an update on that, to make sure that we've got the right information—unless you can speak to that.

**Mr. Saäd Rafi:** At my fingertips, I do not, no.

**M<sup>me</sup> France Gélinas:** No?

**Mr. Saäd Rafi:** I'm sorry.

**M<sup>me</sup> France Gélinas:** No, that's okay. If you take it down on your long list as one more—

**Hon. Deborah Matthews:** Long and growing.

**M<sup>me</sup> France Gélinas:** Yes, the long and growing list.

The next one has to do with Mrs. Sharkey and the long-term-care implementations committee. Will the report be released publicly? Not her initial report; this one, we've had for a number of years, but she did more work on the implementation of it, and that report has not been made public yet.

**Mr. Saäd Rafi:** I'll have to check as to whether we have a plan to do so.

**M<sup>me</sup> France Gélinas:** How do you decide those things, whether those recommendations become public or not?

**Mr. Saäd Rafi:** Again, this is not specific to Ms. Sharkey's report per se, but if we were asking for some advice based on the recommendations, to say, "How

would you go about implementing this? What's the model?", given her deep experience, we might just go about acting on some of her additional advice.

If it was a more formal implementation report, then it might be received in such a manner and then be tasked out for implementation. That could take sometimes many months, many years, depending on the nature of those recommendations. That sector, as you know, is a very diverse and dispersed sector with all manner of ownership structures. I think that that has a direct impact on the ability to implement many recommendations that might come from reports of this nature.

**M<sup>me</sup> France Gélinas:** All right. My next question also has to do with long-term care. This one is on wait-lists for your preferred long-term-care home. I would be interested in knowing the 10% that have been waiting the longest. What are the ranges of times that the 10% that have been waiting the longest has been waiting to get their preferred home?

**Hon. Deborah Matthews:** I think it's important that people—I know you do, but others—understand that a wait-list is a bit of a misnomer, because access to long-term care depends on what your needs are. The CCACs are looking at who most needs this bed when a bed becomes available. The length of time may well have more to do with the preferred space.

We do know that there are some long-term-care homes in this province that provide specialized care, particularly perhaps around language, so that they're culturally specific long-term-care homes. There's a significant demand for those, so people do choose those long-term-care homes and the demand exceeds the supply.

We'll get you the information that we can on long-term-care wait times, but I just think it's important to acknowledge that the length of time you've been waiting really has less to do with getting placed than with your needs at that particular time, relative to others'.

We are very much working on making sure that everyone who goes into long-term care actually needs those kinds of intensive supports. As we strengthen supports in home care, we know that we're going to be able to support more people at home. There are people today living quite independently who would have been destined for long-term care. They were designated in the hospital as people who should be going to long-term care, and actually, after a certain period of recovery, they're doing just fine on their own, perhaps with some supports. There's a lot of change happening in that right now.

**M<sup>me</sup> France Gélinas:** I would have no problem with you putting in a caveat in all of this, but there are still people who are waiting out there; there are wait-lists that exist. I'm guessing that we can bring those together at a provincial level to give us kind of a bird's-eye view as to—I chose the 10%, but you can give me the whole list if you want to.

**Mr. Saäd Rafi:** I think, as the minister said, the type of individual who waits the longest is looking for a very specific type of home: religious, ethnic, cultural and lin-

guistic requirements. That's the top 10% of waits, which is logical.

**Hon. Deborah Matthews:** The other issue that we're very focused on is looking at people who have been waiting the longest in hospital, looking at those real outliers, people who have been maybe designated ALC for months, perhaps because they have a behavioural problem. That's why we're investing more in behavioural supports, to get those people into a more appropriate place. Sometimes, it's hard to place smokers, so we need to accommodate particular, individual situations.

One thing that we're starting to see some success with is that people who are on ventilators don't have to stay in hospital. They can go elsewhere and get that care. And in some of those individual cases, there's not a system solution; there's one, individual solution for that person.

**M<sup>me</sup> France Gélinas:** I think we all have them in our offices.

**Mr. Saäd Rafi:** The average is under 90 days, for all clients.

**M<sup>me</sup> France Gélinas:** Yes, I was looking at the—

**Mr. Saäd Rafi:** Right. The top 10% would be linguistic/religious/ethnic. But to the minister's point, if you happen to be an individual who has that need but in ALC, then it drops very dramatically from there—very dramatically. The priority on someone who has high-acuity needs is there.

**M<sup>me</sup> France Gélinas:** I'm willing to take all of that info in. If you send it my way, I will look at it all.

The next one is another stat that I ask for quite regularly. I don't think it has changed a whole lot, but just in case—the breakdown of for-profit versus not-for-profit: not the number of homes but the number of beds: Where are we in that division? You usually send that response here again with nursing home, home for the aged, municipal home. I don't care how you break it up, but at the end of the day, I'm interested in looking at the number of beds in the for-profit sector versus the not-for-profit. I know the sector enough to know that there are many players in there.

**Mr. Saäd Rafi:** Top line, approximately, or an estimated number of beds: It's 77,400, with for-profit at 53% of those beds, and—I'll round up—47% of those beds are not-for-profit.

**M<sup>me</sup> France Gélinas:** Okay.

**Hon. Deborah Matthews:** And that hasn't changed too much.

**M<sup>me</sup> France Gélinas:** No, it's the exact same number I had before.

**Hon. Deborah Matthews:** Yes.

**M<sup>me</sup> France Gélinas:** Very good. The next one is the inspections done in the long-term-care homes. There seems to be a shift so that, rather than having regular annual inspections, now the inspections are triggered by complaints. I just wanted to know if this was actually happening or if it's not.

1430

**Hon. Deborah Matthews:** There are two kinds of inspections. There are those that are triggered by com-

plaints and, depending on what the complaint is, that will be dealt with immediately. Then there are RQIs, which are more intensive. In fact, I think it takes a team of people 10 days, if my memory serves me well on this, to do a very extensive inspection of a given home. Obviously, the priority is given to those where there appears to be a problem that needs to be addressed immediately. Both of those inspections are done—I think we've had this conversation in the House—there's an inspector in each home—on average just under four times per year. Some of those would be the RQI and others would be because of a reported incident or a—

**M<sup>me</sup> France Gélinas:** Specifically for the regular annual inspection, RQI as you call it, I would like to know how many were done in 2010, in 2011, and the numbers that have been done so far in 2012. I understand that they are inspections that are done following complaints—if you have those numbers you can throw them in, but I'm mainly interested in seeing what kind of a trend we are seeing for annual inspections.

**Hon. Deborah Matthews:** Just to be clear, the RQIs began in 2011.

**M<sup>me</sup> France Gélinas:** Okay, so 2011.

**Hon. Deborah Matthews:** We will get the information on that as best we can.

What I can tell you is that in 2003 there were 59 inspectors, and now there are 81. This includes seven new ones that have recently been added. Last year, on the 630 homes, there were 2,430 inspections completed.

**M<sup>me</sup> France Gélinas:** And does that include both—

**Hon. Deborah Matthews:** That's all kinds of inspections, yes.

**M<sup>me</sup> France Gélinas:** That's all kinds. Okay. If I could have the breakdown as to—

**Hon. Deborah Matthews:** We'll do our best to get you that information, but we are training people up so we'll be doing more of the RQIs.

**M<sup>me</sup> France Gélinas:** I would be interested in knowing, when you do do an annual inspection and you find there needs to be some corrective action, how long before the follow-up is done to make sure that the corrective action has been acted upon—kind of the average time between, “We did the annual inspection. This needed to be corrected”? How long did it take before that work gets done and we checked that the work has been done, if that's how it works?

**Hon. Deborah Matthews:** I think the answer to that would depend on how serious the problem was: Some would require immediate remediation; others perhaps longer. What I'm going to offer to you is, if you would like a briefing with the people who do those long-term-care inspections, they would have more detailed knowledge.

**M<sup>me</sup> France Gélinas:** I will take you up on that.

**Hon. Deborah Matthews:** That's great.

**M<sup>me</sup> France Gélinas:** Sounds good.

**Mr. Saäd Rafi:** It might be more efficient and effective as well, because the minister's quite right; there is a tiered effect of the inspection as to corrective action. It

may have to be done immediately or risk some other more significant sanction, or it may have some period of time.

**Hon. Deborah Matthews:** The other thing that's happening in long-term care that is really improving quality for the participating homes, and there has been significant uptake for this, is the Residents First program, where they're actually developing quality improvement plans, and the front-line staff are charged with the responsibility of identifying and fixing problems. I've had the pleasure of meeting some of those front-line staff who were very pleased to show me the progress they've made, whether it's the number of falls or pressure ulcers or various quality indicators. There's very good work happening in long-term care.

**M<sup>me</sup> France G elinas:** I have heard about them too, and some of the people involved are a little bit, sometimes, reluctant in homes where things don't go that smoothly between management and workers. There have been some issues. One idea that was put forward is that the process that is used by the Ministry of Labour to get information from workers could be used by the Ministry of Health also, so that you make sure that there is freedom of speech for the workers to participate in those. In some homes it goes very well. In some homes, labour-management tension leads to a breakdown in that process, and the Ministry of Labour has developed very good ways to make sure that workers have an opportunity to have a say into a similar type of improvement mechanism. That was one suggestion that was made. When they work good, they do good work; sometimes they don't.

**Hon. Deborah Matthews:** That's good advice. Thank you.

**M<sup>me</sup> France G elinas:** I had a series of questions regarding inspection and follow-up, but if I'm going to get a briefing, then I can leave those aside and ask them when I get the briefing? All right.

Then I will go to a few odds and ends that I hadn't had a chance to do. One of them had to do with a report that came out in 2009—it's a little bit dated, but it was very good. It was called Raising Expectations. It had to do with assisted reproduction in Ontario. More specifically, they were looking at people—young men—who become sterile following cancer treatment for the genital area and how they basically cannot conceive and would very much like to have the help of their government to be able to have a family.

There was some good stuff in this report. Where is it at and is there any intention of implementing any part of it?

**Hon. Deborah Matthews:** That expert panel, as you remember, looked at two issues.

**M<sup>me</sup> France G elinas:** The adoption issue.

**Hon. Deborah Matthews:** The adoption issue, and we've moved on many of their recommendations on that front.

**M<sup>me</sup> France G elinas:** Yes, most of them.

**Hon. Deborah Matthews:** I'm really pleased to see that. On the issues around funding IVF and so on, we're

watching the Quebec experience very closely. You may know that they now fund IVF. This is not a time in our fiscal cycle where we have many opportunities to fund new services, but the argument that the report made was that it actually reduced costs related primarily to multiple births, so we're looking at the Quebec experience and learning from that.

I know that this is an issue that families would like some help with. I think we will continue to follow very closely what's happening in Quebec. I obviously cannot make any commitments. I think all of us feel, when we hear individual stories, that it would be great to be able to help, but at this point it's not something we're moving forward on.

**The Chair (Mr. Michael Prue):** I'm going to stop you there. That's the time. On to the government.

**Mr. Grant Crack:** Hi, Minister. You've done some great work so far. I know that you've got some challenges ahead, but you've also done a great job in meeting some of the challenges in the last couple of years, so I'm proud of the work that you've done and I'm happy to be on your team, that's for sure. Great work on answering some of the challenging questions today as well.

Prior to the summer recess, Minister, we heard some discussion regarding quality of foods in our local schools. There's one party in particular who would like to have cheeseburgers and French fries on a regular basis. I think this side of the House would rather see healthier foods to combat obesity, instead of supersizing everything. Could you tell us what our government is doing to work on childhood obesity in Ontario?

**Hon. Deborah Matthews:** I spoke about this a little bit in my earlier remarks. We have a very serious problem of childhood obesity. We see very clearly that the rates of child obesity are increasing. We know, as sure as can be, that that problem today will manifest itself not too far down the road in increased health costs. It's also, from the perspective of the kids, not the way I think they'd want to live their life.

**1440**

We have set ourselves a very ambitious target: Reduce childhood obesity by 20% over five years. That is a very ambitious target, but it reflects the seriousness of the problem. We know that, whether it's heart disease or diabetes, the future for these kids isn't as healthy as it could be.

We've pulled together a fantastic group of people, who are prepared to give us advice on how to have healthier kids in this province. This group is meeting. They are seeing the perspective—they know there's not an easy solution to this. There are many different factors. Some of it is about the food that our kids eat, but then you have to understand why it is they're eating that kind of food and what we can do to get healthier food to them.

There's the whole issue of activity. As a government, we've introduced 20 minutes of daily physical activity in our schools.

We do have healthier food in our schools. We do think—and I think we differ from the official opposition

on this—that when kids are in our care, in our schools, the food they get should be healthy food. I just completely reject the idea that healthy food can't be tasty food. Healthy food can be very tasty food. We don't have pop machines in our schools anymore; we've got healthier options available for kids. I think we have to not turn our backs on what we've done, but we have to actually do more. I'm looking forward to the report of the Healthy Kids panel.

I just know that there are some things government can do to have a healthier population of young people, but I tell you, government will not be able to do it all by ourselves. This is part of a societal change. Everybody's going to have a part to play, no one more important than parents and family, but it will also involve schools and after-school opportunities for kids to get out and play and be active.

When I met with the Healthy Kids panel, I was pleased to hear that they were also understanding the psychology of obesity, that it's not as simple as "eat less, run around more." There are reasons behind why some specific subpopulations of our children are facing particularly high rates of obesity. You look amongst our aboriginal kids; child obesity rates are extremely high there. There's no question that there is a socio-economic difference, that kids in low-income families get filled up with more carbohydrates than fresh fruits and vegetables. That's part of an economic reality for them.

There's a lot going on. It's complicated, but I just know that if we all work together, we're going to be able to fulfill our dream of making Ontario the healthiest place to grow up and grow old.

**Mr. Grant Crack:** Thank you, Minister. I think a healthy lifestyle is just a matter of habit as well. My step-daughter, Leah, she'll eat fruits and vegetables and olives and yogurts if you provide it to her, but if the chips are there, she'll take the chips.

**Hon. Deborah Matthews:** Yes, we'll go to the chips first.

**Mr. Grant Crack:** I think you're on the right track. As well, I don't know if you could comment on this, but our lifestyles have changed. There's more computer; the kids aren't as active. You touched on active lifestyles. Perhaps you could, if possible, maybe elaborate on some of the advice you think you might be getting from this panel when it comes to lifestyle changes. How do we get the kids away from the computers? Are there any discussions on that, to get them more active?

**Hon. Deborah Matthews:** I really do want to respect the panel. They're looking at the research. These will be evidence-based recommendations. I think it's too easy for us to have the solutions to the problems, so let's look at the research. Let's see what has been successful. Let's see how we can make sure kids have the healthiest possible life.

Some of you maybe were listening to Cross Country Checkup on CBC radio yesterday. They were talking about camping and getting kids away from the screens

and into the outdoors—hikes in the woods. It's good for your body, and it's good for your mind.

I think there's work we all have to do, and I can tell you that if we want to achieve our goal of 20% reduction in five years, there will be lots of work for all of us to get back on the right track when it comes to our kids.

**Mr. Grant Crack:** Thank you. We'll move to another topic: the narcotics strategy. I might have a couple of other questions on nurses as well, depending on how much time we have.

What are we doing as a province to try to reduce—I know you touched on it earlier in your slide deck—prescription drugs, narcotics, controlled substances, medications that people are getting addicted to, and how are we trying to get them off those? Do you have any comments on that?

**Hon. Deborah Matthews:** Again, we turned to experts to come together from their various perspectives and experiences to develop our narcotics strategy. I can tell you that the people who came to be part of that strategy brought with them an absolute determination to really drive some change. We've moved on many of those recommendations.

When we can prevent an addiction, that is the best. Our doctors, our dentists, our other prescribers need to be educated on what is appropriate pain management. That work is under way.

We have the database now that actually will be able to capture prescribers, dispensers and individuals who are abusing prescription narcotics.

OxyContin is now off the market, and OxyNEO is on the market now, OxyNEO being a tamper-resistant form of OxyContin. OxyNEO is available only through the Exceptional Access Program, so it's not something that can be prescribed as easily as OxyContin was.

The reliance on prescription drugs has been devastating in all of our communities. It is a very, very serious public health problem.

I have written to the federal minister—and they will have a proposal on the generic form of OxyContin. I have asked the federal minister to direct her officials not to list that for sale in Canada, because we now finally have OxyContin off the streets, and the last thing we need is for an even cheaper form of the same drug to be back on the streets. I'm hoping that she will pay attention to that request. I know that other health care professionals are making the same request. We can't always control what comes across our borders, but we can control what is sold in our pharmacies. I think it's very important not to reintroduce that very problematic drug into Ontario.

We've also got the treatment for people who are addicted. We are monitoring very closely what's happening on the street. We had hoped that removing OxyContin would actually trigger some people to actually choose this moment to come into treatment, so we want to make sure that we've got treatment available to people who are ready to address that.

There's a drug called Suboxone. For many people, methadone is very helpful in getting off opioids.

Suboxone is another drug, and we've made sure that it's available through Exceptional Access, but we're making sure that when there's an application, they get an answer within three days.

**1450**

We're really speeding up access to Suboxone, and we've seen some very compelling success stories, particularly in our First Nations communities, where they combine Suboxone treatment with culturally based programming and supports. It's extraordinarily moving to have people talk about their journey and how they finally got the help that they needed. We've got chiefs who have declared states of emergency in their communities because of addiction to prescription narcotics. We've seen communities devastated. In some communities, I've had chiefs tell me that 80% of their residents have an addiction.

We're also focusing on pregnant women who are addicted, because that is a very specific medical condition. We need that baby to be as healthy as can be, but we know that a baby born to a mother who is addicted is also addicted. We need to be there to support the woman through the pregnancy, and that child when the child is born. So there are a number of initiatives that are happening across the province.

I'm not naive enough to think that just removing OxyContin from the streets is going to solve any problems. We know that addiction is complex and that people will look for other options, but we need to be there to prevent addiction in the first place and to support people when they're ready to take the step to deal with that addiction.

**Mr. Grant Crack:** That's a very good point, because you're touching on something that's very close to home for me. There's someone very close to myself who—they're foster parents and they do have a baby about three to four months old. The mother was addicted, and now they're looking at probably a lifetime of operations and special care that's going to be required.

If we look at the costs of perhaps dealing with addictions early on and preventing, as we're doing, I think that's great, because the cost to not only the quality of the human life but the cost to maintain a good quality of life is excessive as well. Keep up the good work on that. That's great.

How much time do we have, Mr. Chair?

**Hon. Deborah Matthews:** If I could, there was something I should have added.

**Mr. Grant Crack:** Oh, sorry.

**Hon. Deborah Matthews:** The development of a narcotics strategy was one of the recommendations from the Select Committee on Mental Health and Addictions, which was a three-party committee that did extraordinarily fine work. I know France was on that panel, and others. I just wanted to pay tribute to the members of that committee, who gave us the advice to move forward on that.

**Mr. Grant Crack:** Good.

**The Chair (Mr. Michael Prue):** And you have about five and a half minutes.

**Mr. Grant Crack:** Does anybody else want to go, or do you want me to keep going? I have one more.

**Mr. Michael Harris:** Just pass the time.

**Mr. Grant Crack:** No, no—unless you want to take a break.

Minister, I recently visited, in Hawkesbury, the family health team there. I was extremely impressed. It was my first opportunity to see the good work they do. The enthusiasm coming out of that particular facility is extraordinary. They're getting up and going, and they're ready to continue.

Maybe you could just talk about some of the great components of what the family health teams do and the benefits they provide to a community of, say, 9,000 or 10,000, such as the Hawkesbury area, perhaps. Could you elaborate?

**Hon. Deborah Matthews:** Under Minister Smitherman we began to open up family health teams, and I can tell you that they are a wonderful success. Whether it's the patients, who have access to services they would otherwise not have access to in a coordinated way, or the providers, who can get their patients the care they need and work in a team-based setting—they really are a great model of what we can do when we all work together.

We have now 2.8 million people who are rostered at family health teams. As I say, I think the patients, the providers would all say that this is an excellent model of care. The Auditor General has given us some advice on what we need to do to ensure that we're getting best value for money, and we are, of course, following up on the Auditor General's recommendations. But from a quality-of-care perspective, I think they are doing extremely well.

One of the things I talk about is access to care when patients need it, so that they get the care they need from their family doctor and they don't have to go to the emergency department; 168 of the 200 family health teams do have same-day/next-day appointments now, as part of the way they book patients. What they do is they reserve a block of time every day—several hours, usually—for same-day/next-day appointments. It takes some adjusting when they begin to schedule their time differently, and I think it looks a bit scary for them to see blocks of empty time. But what they're learning is that time does get filled up. When we have so many people going into emergency departments who say they would go to their family doctor if they could get care when they need it, we know that that shift to same-day/next-day is absolutely the right way to go. We are inspired by that, and we want to see more of that across the province.

When I hear of a mum who has a baby with a suspected ear infection and she calls the family doc and they say, "Come in a week Thursday"—no mum is going to keep their child, who's in pain, away from the care they need for that length of time. When your child has an ear infection they need to get treated, and they need to get

treated right away. Too many of those folks are having to go to walk-in clinics or emergency departments.

Family health teams are proving to be a great success. We've gone from having to work hard to get doctors to participate in family health teams to, now, a lineup of doctors who want to be part of a family health team. It's one made-in-Ontario initiative that is very positive.

**Mr. Grant Crack:** Excellent. Finally, you recently announced the creation of 900 new nursing positions. Could you explain, perhaps, where they're going? Do you know whereabouts they go across the province? Is it more in the city of Toronto? Is it dispersed proportionately?

**Hon. Deborah Matthews:** No, they're geographically spread out right across the province. I can give you what these nursing positions are at a high level.

So 126 of them are rapid-response nurses. They work with people—maybe I used the wrong term earlier today. They work with patients who have been discharged from hospital. They're seen within 24 hours at their own home to make sure that they are connected; they've got the right follow-up appointments; they have their Meds-Check done; they're settled; they've got the right home care supports—so 126 rapid-response nurses to care for people who are being discharged from hospital.

Two hundred of them are for long-term-care homes, to care for people with complex and challenging behaviours. It could be a form of dementia or another challenging behaviour, where extra-special care is required.

There are 191 telemedicine nurses to support patients as they do that remote hookup through the Ontario Telemedicine Network.

There are 144 nurses in schools, and they are focused on students with mental health and addiction issues. Again, it's about identifying those problems early. You know that when there is a student in school who is suffering with a mental health problem or an addiction issue, it affects far more than just that one student; it affects the whole classroom, it affects the teachers. We know we can do better by identifying those students earlier, by attaching them to the right supports earlier. Hopefully, a little intervention early will prevent a much larger intervention later.

**The Chair (Mr. Michael Prue):** I'm stopping you right there.

The last full round: to the Conservatives.

**Mr. Michael Harris:** Thank you, Chair. Minister, I'll change track just slightly from eHealth. I'll give you a bit of a break on that. I know my colleague will come back to that halfway through this session.

1500

I wanted to get to June 20. That was the last question period that we had here at the Legislature, and I asked you about the evaluation of the Niagara ambulance communications pilot project. Now, your answer entailed a lot about how nice our local police chief is, and I will agree with you, he is a good guy. But I wanted to get to the bottom of the question; I'm hoping that we can do so today. I'll start off simply by asking if you will table the

report evaluating the Niagara EMS dispatching pilot project in full to this committee today.

**Hon. Deborah Matthews:** I will take that request, as other requests from the committee, and we'll see what we can do. I can—

**Mr. Michael Harris:** I'm looking for a yes or no, actually. Will you table that report that I'm asking for as a member of the standing committee, as per section 110(b) of the standing orders? Will you table that report today, in full? Yes or no?

**Hon. Deborah Matthews:** I will look into the feasibility of doing that, and if I can, I will.

**Mr. Michael Harris:** So that's a yes?

**Hon. Deborah Matthews:** What I can tell you is that I met with Regional Chair Ken Seiling. I met with the—I forget his name—the CAO, I think, of Waterloo region. John Milloy set up a meeting; he attended as well. We had a very good conversation about this particular issue.

**Mr. Michael Harris:** During that meeting, Chair Seiling asked for the ability for the region to control regional dispatch of ambulance.

**Hon. Deborah Matthews:** That was the reason for the meeting.

**Mr. Michael Harris:** Did you say yes or no to that request?

**Hon. Deborah Matthews:** What I said is that we would work with the regional municipality. We have a provincial ambulance dispatch system now that supports care across the province, so to take Waterloo region out of that provincial system is not something that I would take lightly. It's important that we have a provincial ambulance dispatch system. But I do think, coming from that meeting, that it's important to me that the ministry understands the issues raised by Waterloo region—

**Mr. Michael Harris:** Good.

**Hon. Deborah Matthews:** —and that we work together to find solutions that meet the interests of everyone.

I am very pleased that we are moving forward as a pilot project in the Waterloo region: the simultaneous dispatch of fire and ambulance. That will get care to people faster. That is an important step, and I suspect that you are pleased that your region was chosen as a pilot for that. We will look forward to the results of that pilot.

**Mr. Michael Harris:** Just for the record, I want it noted that I have asked for that report evaluating the Niagara EMS dispatching pilot project to be tabled to this committee or delivered to the committee, as per those standing orders, reference 110(b), within 30 days.

Minister, back to that: Why was the Niagara ambulance communications pilot project commissioned in the first place?

**Hon. Deborah Matthews:** That would have predated my time as minister, I believe, so I'm not—have we got someone who can answer that?

*Interjection.*

**Hon. Deborah Matthews:** Patricia Li, ADM—

**Mr. Michael Harris:** You are aware of the fact that the region does control dispatching in Niagara; correct?

**Hon. Deborah Matthews:** Yes; and also Toronto and Ottawa have slightly different dispatch systems. I'll ask Patricia Li to answer your question.

**Mr. Michael Harris:** So my question to the minister, obviously, was why the Niagara ambulance communications pilot project was commissioned in the first place and was it actually a way to find a better delivery model for EMS dispatching services in Ontario, for Niagara?

**Ms. Patricia Li:** The information that I have: The pilot project predates my arrival at the Ministry of Health and Long-Term Care, but since my arrival we have made the arrangement permanent with the Niagara region.

The pilot was established as a technology upgrade to test dispatch technology. It wasn't set up as a pilot to test the delivery system. That was my understanding. So when you were asking about the Niagara pilot project report, which is really the ownership of the Niagara region, I think the minister is quite correct. We have to look into it and review it with the people who own the report, which is the Niagara dispatch—

**Mr. Michael Harris:** So there was a report done at the end of the five years of the pilot, right?

**Ms. Patricia Li:** Yes. There was an evaluation and there was a report. It was conducted jointly by the ministry and the Niagara region. It was to report on the results of the technology of the dispatch system.

**Mr. Michael Harris:** Where is that report today? Is it public?

**Ms. Patricia Li:** It is not a public report.

**Mr. Michael Harris:** Why not?

**Ms. Patricia Li:** We will look into it.

**Mr. Michael Harris:** Why isn't that report public?

**Ms. Patricia Li:** Because it is not in the ownership of the ministry. The report is owned by the Niagara region.

**Mr. Michael Harris:** The report is owned by the Niagara region?

**Ms. Patricia Li:** Yes, because as part of the pilot project, there's a condition on the project that the region do an assessment of the project.

**Mr. Michael Harris:** Yes, but the ministry conducted the report to evaluate the test pilot, so that was done by the ministry, not the region—the ministry. The ministry did the evaluation.

**Ms. Patricia Li:** The ministry did not do the evaluation. It was conducted by a consulting firm.

**Mr. Michael Harris:** Okay; the ministry consulted the firm to commission a report.

**Ms. Patricia Li:** It was a condition of the pilot project agreement.

**Mr. Michael Harris:** So who paid for the report?

**Ms. Patricia Li:** The Niagara region, through their funding.

**Mr. Michael Harris:** From the ministry.

**Ms. Patricia Li:** I assume that would be the case.

**Mr. Michael Harris:** Right. Minister, have you read the report?

**Hon. Deborah Matthews:** I have not read the report.

**Mr. Michael Harris:** So I can't ask you what you think of the report. My question is, why has the report never been released to the public?

**Hon. Deborah Matthews:** I think ADM Li has answered that question, and I think I have committed to looking into the feasibility of releasing it, so we will—

**Mr. Michael Harris:** Well, Minister, many chief paramedics have suggested to me that you won't disclose the report evaluating the Niagara EMS dispatch centre because it proves that regionally operated dispatching is far superior to provincially controlled dispatching. Would you agree with that?

**Hon. Deborah Matthews:** I don't tend to respond to speculation, so let's see if we can release that report for you.

**Mr. Michael Harris:** Minister, a number of regional officials, including officials in Waterloo, where Rob and I both come from, have asked your government to leave EMS dispatching to the municipalities. You can, of course, continue to refuse, saying that any proposal to have a regional dispatch centre should include evidence that such a centre would provide patient safety and produce cost savings. I'm not sure if any one of the three of you can answer this: Isn't that detailed in the report done on the Niagara system?

**Ms. Patricia Li:** No, I don't believe so.

**Mr. Michael Harris:** Again, I just want to reinforce the fact that I've asked for that report to be tabled.

I'm not sure, are you aware of the FOI request submitted by AMEMSO for this report?

**Hon. Deborah Matthews:** I leave FOIs to ministry officials.

**Mr. Michael Harris:** Deputy, are you aware of the FOI request from AMEMSO to have access to this report?

**Mr. Saäd Rafi:** I'm aware of the FOI request, but now I know the requester. I did not know the requester, but I am aware of the request.

**Mr. Michael Harris:** It says in here that you're charging municipal association fees for this report, done and paid for by the taxpayer. It says in here that some items may be severed from the records. Why would you sever such information from a report that has been paid for by the taxpayers on an important aspect of ambulance dispatch that can save lives and save the taxpayer money?

**Ms. Patricia Li:** I'm not entirely sure which document you're referring to. If I can read the document?

**Mr. Michael Harris:** Well, I'd love to read the document too, and that's the document I'm referring to as the Niagara ambulance communications pilot project report. Perhaps we'll just leave it at that and hope that that report, in its entirety, non-redacted, gets tabled to this committee within 30 days. I would like to have that noted.

**The Chair (Mr. Michael Prue):** Yes, but just on that point, just in case it's not abundantly clear, 30 days is the time frame at which time the clerk will send out a reminder. Generally, we expect it within 30 days, but there is no guarantee. If it does not arrive, a reminder will be

sent, but it has been my experience over the years that most of the reports do come within that time.

**Mr. Michael Harris:** All right—

**The Chair (Mr. Michael Prue):** Not all of them, though.

**Hon. Deborah Matthews:** Would you be kind enough to tell me what AMEMSO is?

**Mr. Michael Harris:** It's the association of municipal emergency responders—I can give you what the full name is, but it's the association for emergency responders, AMEMSO.

**Hon. Deborah Matthews:** I have enough acronyms to keep track of. I wasn't familiar with that one.

1510

**Mr. Michael Harris:** I hear you. I'm going to pass it to Rob. I know he's got some other questions on—

**Mr. Rob Leone:** Thank you very much. Minister, earlier, my colleague Mr. Harris talked about a report from the Canadian Medical Association Journal. We are able to provide the author of the journal article. His name is Paul Christopher Webster. The title of the article is "Diabetes Registry Overdue, If Not Obsolete." It's found in the June 12, 2012, edition of the CMAJ, volume 184, number 9. It was published on May 14, 2012.

Minister, I'm kind of curious. It seems that we have maybe caught you off guard with this. I'm wondering, how are you made aware of such reports that are affecting parts of your ministry? What's the process involved for people to identify articles—

**Hon. Deborah Matthews:** I believe you're talking about a specific article that appeared in a specific journal. Is that what we're talking about?

**Mr. Rob Leone:** Yes. Well, just in general, how are you made aware of issues in your ministry?

**Hon. Deborah Matthews:** I have regular and ongoing briefings on various issues. People write to me. People I meet might recommend or even supply me with articles.

**Mr. Rob Leone:** Have you been made aware of this article?

**Hon. Deborah Matthews:** I haven't read the article. I did hear that that article had been written.

**Mr. Rob Leone:** Okay. We have a copy of that article that we'd like to distribute for you, if we could do that.

**Hon. Deborah Matthews:** Terrific. One source of information that I would happily refer members of this committee and others to is HealthyDebate. It's a website that has health practitioners who have very interesting perspectives on various aspects of the health system. There are many sources of information on health care, both in Ontario and internationally.

I do my best to keep abreast, and I count on my officials, obviously, in their particular areas, to be very much on top of the literature.

**Mr. Rob Leone:** I would like to ask a question on the last page of this article, the last paragraph. Previously, Minister, you answered in relation to a question that was posed by my colleague here, Mr. Harris—he asked whether CGI had received any funding, and your response was that to your knowledge there were zero dol-

lars transferred. In the last paragraph of this article, it suggests that Infrastructure Ontario has "claimed that a 'value-for-money assessment' from the professional services firm Deloitte and Touche LLP which endorsed the government's decision to pay an additional \$6 million to CGI to develop the project using a privatized funding, operating and ownership model"—a website is cited—"was justified despite the firm's failure to deliver the system on time." Does that indicate that money has in fact been transferred to CGI?

**Hon. Deborah Matthews:** I don't read it that way at all, but I will ask the deputy to comment on that.

**Mr. Saäd Rafi:** I just read the paragraph, let alone the article. I find it interesting that the operative phrase in the paragraph follows the link, which is about the contract, I suspect. Again, I don't really want to speculate.

I would say that the financing associated with an alternative finance and procurement might—and I want to emphasize "might"—explain that \$6-million amount. That doesn't, though, to me, on just one quick listening of the reading, indicate that there's some link to this last partial sentence that follows the Web link in the article.

I'm not trying to be circular, but on a cold read, not knowing the context of what the rest of the article talks about, nor what this reference to \$6 million is, it's the only thing I could speculate on.

**Mr. Rob Leone:** Isn't it odd for procurement projects and for companies who have large, multi-million dollar contracts awarded to them by the government not to have a stepped payment plan, where they take a third of the funding upfront to pay for incidentals in the course of doing their work, maybe two months or two years or a period of time later get another third and upon completion get the balance of it? Isn't that the normal practice for companies who are engaged in contracts of millions of dollars, to have some way of getting some money before the actual completion of the project?

**Mr. Saäd Rafi:** I think you're referring to what I would sort of call a pay-as-you-go approach to contracting.

**Mr. Michael Harris:** Progress payments.

**Mr. Saäd Rafi:** Sorry?

**Mr. Michael Harris:** Progress payments, or whatever.

**Mr. Saäd Rafi:** Okay, or a stipulated sum that you would make progress payments against.

The choice that was made on the diabetes registry was to use a public-private partnership model, or alternative financing and procurement, whereby there are not progress payments until substantial completion, so the financial and delivery risk is with the vendor. That means that upon substantial completion, as dictated in the contract, RFP'd at the outset, a payment would be made because it's substantially complete and it's accepted by the client or the owner of the particular asset—in this case, the diabetes registry.

In this case, it would not be normal to have progress payments or pay-as-you-go in this type of model. That's why I was trying to reference that I thought perhaps the statement about an additional X dollars—although I don't

know about the additional—was given to CGI or part of their privatized funding. That's their financing aspect, but they have to take on that financing risk if they don't deliver.

**Mr. Rob Leone:** Why does the government continue to retain CGI if substantially no work has been done on the diabetes registry?

**Mr. Saād Rafi:** I would say eHealth Ontario perhaps wouldn't agree with no work being done on the diabetes registry. I think they feel that there's progress being made. They have, I think, been quite open to say that both parties, eHealth Ontario and CGI, haven't met the mark on timelines. I think both parties feel there's an opportunity to hit the production release and that they're working toward doing that, if I'm not mistaken.

**Mr. Rob Leone:** How do you think Ontarians would respond to some of the comments that we've heard on-going today with respect to the questions that this committee has posed to you, Minister? I think you've stated on a number of occasions that you recognize that these projects are late, and you've acknowledged that. How do you think Ontarians are going to respond to that, given the fact that they continue to be late, they continue to be past their deadlines? Do you think they'd accept such a response?

**Hon. Deborah Matthews:** I think it's important that we go back to what happened when new leadership took over at eHealth Ontario. They took a step back and they looked at the work plans that were in progress, and they developed a new strategic plan so they could deliver on projects, get the best value for money, and see measured, step-by-step improvement and building of our electronic medical records.

We have made significant progress in the last few years under this kind of leadership, this kind of management. There was a decision made, back when the new leadership came into place, to revisit the planned projects that formed part of the whole eHealth initiative. They were very public about coming forward with a new strategic plan that actually made more sense than what had been going on before, when there were a number of projects under way. We have a very deliberate strategy. The people at eHealth have a very deliberate strategy to focus on projects, to get them done. That explains much of what we've talked about today.

When it comes to the diabetes registry, I expect Ontarians to feel exactly as I feel, which is, "That should have been done on time." It should have been done on time. I have every confidence it will get done, and taxpayers are not going to pay for it until it is done.

**Mr. Rob Leone:** But who's going to be responsible for that?

**The Chair (Mr. Michael Prue):** I'm going to stop you there, because I think that's the time.

**Mr. Michael Harris:** Thirty seconds.

**The Chair (Mr. Michael Prue):** Oh, sorry; 30 seconds.

**Mr. Rob Leone:** But who's going to be responsible for that, I wonder? Minister, we've seen these prolonged delays.

Also, the Toronto Star is breaking today that your deputy minister has received a contract extension, being the highest-paid bureaucrat in the Ontario public service.

Who's going to be responsible for all the delays and the lateness of things that are going on in your ministry?

**Hon. Deborah Matthews:** Well, first let me say that I am delighted that our deputy has chosen to sign an extension to his contract. It is a very challenging job regardless of who is minister, but particularly hard, probably, because I'm the minister. I'm very pleased that he is staying on in the job and, I think, deserves to be well compensated for that.

1520

When it comes to procurement, I just want to make it very clear that our procurement process is much cleaner, much fairer, much more transparent than it was under the previous government—

**The Chair (Mr. Michael Prue):** Okay, I'm going to stop you there because that's time.

Okay. Final opportunity for the NDP.

**M<sup>me</sup> France Gélinas:** Final opportunity. Well, I will pick up a little bit as to what has been driving my colleagues all day—what's happening at eHealth—and pick up on your last comments that you're committed to transparency and accountability and all this. If what I've heard today about eHealth has little based in reality, I think it would help if the minister shares with us how many of the present employees were consultants before, when it was Smart Systems for Health. One way to do this would be: Would you be able to release to the committee the list of hires at eHealth, let's say for the last 12 months, so that we could see the names of the people? We have a pretty good idea of who worked there before, and if you share with us who works there now, it could help put a lot of conjecture to rest.

**Hon. Deborah Matthews:** We will do our best to get you that. What your question really is is: How many people who were previously consultants are now employees? That's the question?

**M<sup>me</sup> France Gélinas:** Correct. That's the question.

**Hon. Deborah Matthews:** Well, let's see what information we can get for you.

**M<sup>me</sup> France Gélinas:** What happened in 2009 was a scandal. If Ms. Sarah Kramer was to apply for a job at eHealth today, would she be considered?

**Hon. Deborah Matthews:** I don't do the hiring at eHealth Ontario, but I would wager that the answer to that would be no.

**M<sup>me</sup> France Gélinas:** It would be no? But I guess it's more of a question of, when we turned the page on that episode and eHealth was put into place, chronic disease management was put forward, and the diabetes registry is something that kind of built momentum. We all saw this as, "This could be an eHealth project that could help us turn the page." Once the registry is in place, we could all see clinical implications for why that would make sense.

But all of this is for naught if what we had before is creeping back in.

I was happy that you shared with us that there are only 50-some consultants left at eHealth. Then comes this fixed-fee contractor. Like you, I have no idea what those are, but I would certainly be interested in knowing: Of the people who receive money from eHealth, which ones are employees and who are they? And the consultants—here again, who are they? If there are such things as fixed-fee contractors, who are they, what do they do and what percentage of money goes to those people? I'd like to basically get reassurance that all is not as bad as what I've heard all day today.

**Hon. Deborah Matthews:** I think it's important to underline that there is tremendous progress at eHealth Ontario. We've got great success on uptakes of EMRs—60% and growing of family docs. We've got eCHN; that's two million children with electronic medical records. We've got ConnectingGTA—ConnectingGTA is huge. When you get 700 providers able to share information amongst themselves, that is a very, very big step forward in linking information that will have a profound impact on patient care. We've got the drug profile viewer, so that the drugs that people are on are available in those ERs across the province. There is a lot of excellent progress being made, whether it's telemedicine or things like ENITS or the shared diagnostics information. There's a lot of progress that's going on, and I think we maybe hid some of the light under a barrel, because we have seen steady progress when it comes to moving toward that goal of everyone in Ontario with an EMR by 2015.

We're on the way, and it's going very well. Is it going perfectly? No, and the delay on the diabetes registry is one of those that—I am very disappointed that we don't have it up and running. The vendor has not met the deadline that was set—not for lack of work by people at eHealth and Infrastructure Ontario and in the ministry.

We're moving forward, and it's very good progress.

**M<sup>me</sup> France Gélinas:** I guess, in some circumstances, I'm willing to accept a setback. Only people who do nothing never fail.

**Hon. Deborah Matthews:** Exactly.

**M<sup>me</sup> France Gélinas:** What I'm not as willing to accept is that if the culture that was there before, of executive compensation and use of consultants, of sole-sourced procurement—it seemed like the page had been turned. There were clear guidelines regarding procurement. There were clear guidelines regarding executive compensation etc. Are those guidelines still clear? Are they being followed? Do we know that they are? Are the consultants that are there—and whatever those fixed-fee contract people are—who are they? What does that mean? I've sat there, like you, for seven hours, and my colleagues have used their part of the seven hours to focus on this solely.

As I said, I'm willing to say they tried really hard; they failed in one area; they succeeded in others. But I'm not willing to give consultants an open credit card to government resources.

**Hon. Deborah Matthews:** And neither are we. There is very strong oversight at eHealth Ontario. The procurement rules are adhered to. We have a Fairness Commissioner to ensure that procurement is fair. We will continue to drive the kind of change—but there is a new culture at eHealth Ontario, and there are demonstrated results.

**M<sup>me</sup> France Gélinas:** Can I find out how much money is being spent on consultants, and, if those fixed-fee contractors exist, can I find out how much money is being spent on those people and how many are we talking about? We know we're talking 50-some consultants, but are we talking each and every one of them with a \$5-million contract?

**Hon. Deborah Matthews:** We'll get you that information, but I'm sure the answer to that is no. I would love to hear from the official opposition on how exactly they define a fixed-fee contractor. I would look forward to information from them on that.

**M<sup>me</sup> France Gélinas:** Okay. You've assured me today that the procurement rules are being followed—

**Hon. Deborah Matthews:** Absolutely and rigorously.

**M<sup>me</sup> France Gélinas:** —and we know that for a fact. The same thing with executive compensation and the same thing with the sole—because we had a lot of sole contracts. None of this is going on anymore.

**Hon. Deborah Matthews:** None of that is going on.

**M<sup>me</sup> France Gélinas:** Okay. We've had one setback with the diabetes registry, which—we hope the rest of them do good, and one didn't, is how you classify it.

**Hon. Deborah Matthews:** Yes.

**M<sup>me</sup> France Gélinas:** Okay. Well, any information that you can share as to the percentage of money going out to the different forms of employment contract and human resources, whether they're called fixed-fee or otherwise, I think that would help me feel comfortable that eHealth is going on the right path and had one setback on one of their projects, while others moved forward the way they were supposed to.

**Hon. Deborah Matthews:** It makes perfect sense, depending on the projects that are being worked on at a given time, that people are brought in on contract.

**M<sup>me</sup> France Gélinas:** Yes.

**Hon. Deborah Matthews:** Sometimes that's the right decision to make, so we'll keep that in mind.

I can tell you that the Auditor General gave us some very clear instructions back in 2009, and I can tell you that all of his recommendations have been addressed. So we learned from that experience.

1530

**M<sup>me</sup> France Gélinas:** If all of this is good, but I was to look at the list of employees and recognize half of Courtyard staff that is now moved over, I would probably have a little bit of, “Oh. We were supposed to turn the page on those high-priced consultants. I hope they didn't find their way back in through the back door, through some kind of other form of employment.”

**Hon. Deborah Matthews:** You also would know that they report on the sunshine list, so you would see.

**M<sup>me</sup> France G elinas:** Yes, true.

Back to other health-related questions: The first one has to do with mental health. I thank you for your mention of the special committee for mental health and addictions. Our number one recommendation, after 18 months and many, many days of hearings, was the creation of what we called Mental Health and Addictions Ontario, basically giving mental health and addiction a home, which they never had. I mean, we had 12 different ministries come to the Select Committee on Mental Health and Addictions to tell us how their little part fits into the mental health and addictions system.

Is there any willingness to move ahead and give mental health and addiction a home at some point?

**Hon. Deborah Matthews:** You know that we released our mental health and addictions strategy, that built on the recommendations from the select committee and from the advisory group that was set up by David Caplan.

**M<sup>me</sup> France G elinas:** Yes.

**Hon. Deborah Matthews:** And the first five years of that strategy are focusing—not exclusively, but the bulk of new investment is focusing on children and youth. The Minister of Children and Youth Services is the lead minister on that. The Minister of Education also has an important role to play because schools are where kids are.

We have set out a very clear addictions and mental health strategy that we are implementing. I dare say that that initiative is a direct result of the excellent work that was done by you and by your fellow committee members.

To answer your specific question, are we looking at sending—I think the comparison was made to Cancer Care Ontario. The answer is no, that’s not something we’re looking at doing right now, but we have a very clear action plan for the next five years, focusing first on children and youth.

**M<sup>me</sup> France G elinas:** Okay. The second question—they’re not related—has to do with HPRAC. I have been approached, and I’m sure you have, by many colleges, provisional colleges, for new professions that will be coming under HPRAC. They are confused as to the process that is to be followed. A lot of them are not happy with the reviews that are being done of their scope of practice in the first college that will be put into place. I was hoping somebody could explain to me how you go from having a transitional college to having a college that will be one of the 27 colleges for health professionals.

**Hon. Deborah Matthews:** Just to be clear, you’re talking about professions where there is already a transitional council?

**M<sup>me</sup> France G elinas:** Yes.

**Hon. Deborah Matthews:** That transitional council has a lot of work to do to establish the standards and set in place what will become a college. Each of those transitional councils is doing that work now. Some are moving smoothly, others not so smoothly. That is the job of the transitional council—

**M<sup>me</sup> France G elinas:** And what’s the relationship to the ministry? How much of the decision-making is with

the transitional council versus with the ministry, and where does the back-and-forth happen?

**Hon. Deborah Matthews:** I’m not sure who could speak to the transitional councils.

**Mr. Sa ad Rafi:** The assistant deputy minister Suzanne McGurn is not here, but I was part of our health human resources strategy division. That is the division that has very regular interaction with the transitional and all the other colleges. It’s not as if we are directing them, but we have a very strong stakeholder relationship with them, as we would with the colleges.

**Hon. Deborah Matthews:** The goal for each of those transitional councils is to do that foundational work so they can be a regulating—

**M<sup>me</sup> France G elinas:** A full-fledged college.

**Hon. Deborah Matthews:** —college, so there’s a lot of work that has to go into that: developing the scopes of practice, the membership arrangement. There’s a lot that has to happen. They’ve got important and difficult work to do.

**M<sup>me</sup> France G elinas:** Because the complaints that we get are along how the transitional council wants to go in this direction and do the hard work in that direction, and they get told, “No, the ministry wants you to go that way,” and then they report back to their transitional membership and say, “No, we won’t be able to go this way, the way that the membership wants us to go. We’re going to have to go this way because this is what the ministry wants.”

The part that I’m not clear on is who has the final decision-making ability and at what point does the transition council become a college that would then be at arm’s length from the government to direct their members. There seems to be grey zone where there are a lot of unhappy campers.

**Hon. Deborah Matthews:** I think it’s fair to say that some of those transitional councils are moving forward, but they’ll never have unanimity. If there are specific transitional councils you’ve got concerns about, I’d be more than happy to talk to you about those specific transitional councils, but ultimately, the goal is that they will form regulatory colleges where they will be able to deal with complaints from the public.

I think it’s important to remind ourselves that those self-regulatory colleges are responsible to the public, not to the profession. Their job is to protect the interests of the public. I never miss an opportunity to remind people that in the checks and balances, those colleges play a vitally important role.

**M<sup>me</sup> France G elinas:** I may take you up on your offer.

The next one is, in April this year, you talked about further reductions in generic drug prices.

**Hon. Deborah Matthews:** Yes.

**M<sup>me</sup> France G elinas:** And I was wondering if there is any intention on behalf of your government to move ahead with those.

**Hon. Deborah Matthews:** The answer is yes. That was part of the deal we made on the budget with your

party. So yes, we are further reducing the price of some generic drugs. That work is under way as we speak.

**M<sup>me</sup> France Gélinas:** In that work—the last time we did this, there was quite a bit of hardship that was brought upon independent pharmacists, mainly in rural communities, where some of them closed and a big Shoppers Drug Mart opened up in the cities next door. I wanted to make sure that some consideration would be given to making sure that small, rural communities continue to be served by pharmacies and pharmacists through the transition, whichever way that leads us.

**Hon. Deborah Matthews:** When we were doing the first round of drug reforms, when we cut the price of generic drugs from 50% to 25%, we eliminated professional allowances. We increased dispensing fees, and you will recall that we made significant efforts to keep those small, rural pharmacies viable by significantly increasing dispensing fees paid in those small communities. There were suggestions that we would see a lot of pharmacies close as a result of that. In fact, we've seen a net increase in the number of pharmacies across the province.

We continue to see access to pharmacy care as an important part of—access to pharmacy care is part of access to health care.

**The Chair (Mr. Michael Prue):** Two minutes.

**M<sup>me</sup> France Gélinas:** Okay. The next two questions have to do with the big book that I tried to read.

**Hon. Deborah Matthews:** The big blue book?

**M<sup>me</sup> France Gélinas:** Yes, the big blue book. I'll even give you the pages in the English side, which is page 135 and, then again, page 141. They have to do with lines that—we're looking at transfer payments. There are a whole bunch of them: Cancer Care Ontario, Canadian Blood Services, chronic disease management, HIV/AIDS, Ontario Breast Screening Program, and community and priority services. Those people received \$2.6 billion and I have no idea who we're talking about. It's page 135 of the big blue book. They're just above the healthy homes renovation tax credit at the bottom of the page. Who are they?

1540

**Mr. Saäd Rafi:** Those are not agencies per se; those are priority programs that would be net of cancer services etc. etc. We can get you a cross-section or a list of what we call provincial priority programs. They are—

**M<sup>me</sup> France Gélinas:** Okay. I would—

**Mr. Saäd Rafi:** Sorry.

**M<sup>me</sup> France Gélinas:** That's all I'm looking for: a list of which programs are included and how much they are getting, because there's a significant amount of money in there.

**Mr. Saäd Rafi:** Right, and a lot of that money would end up delivered via hospitals for various types of initiatives: critical care, CritiCall etc. I might have a breakdown—

**M<sup>me</sup> France Gélinas:** Okay, an answer is coming quickly? Oh, wow. But I have one more, if it's going to take you a long time to read it. I want to use my two minutes wisely.

**Mr. Saäd Rafi:** Oh, sorry. Well—

**The Chair (Mr. Michael Prue):** No, no. Your two minutes are up.

**M<sup>me</sup> France Gélinas:** Page 141, I have another one: ambulance and related emergency services—

**The Chair (Mr. Michael Prue):** Your time is up, but I want everyone to rest assured, the clerk advises me that there was an additional 10 minutes for each party on the next round. Okay?

We have the Liberals next for 20 minutes, and then there is 10, 10 and 10.

**Mr. Phil McNeely:** I had a few questions. We were talking about lugging around the X-rays for my knee operation when that session was over. How does eHealth benefit rural Ontarians right now? What have we got that we've done that is helpful there?

**Hon. Deborah Matthews:** So eHealth benefits everyone. One of the things that I think about when I think about access in rural Ontario, I can't think of a better example than the Ontario Telemedicine Network. We have experts with a specific specialty where, perhaps, someone would have to travel quite a distance to access that care. With telemedicine, they can hook up with one of the many, many eHealth—I don't want to call them a studio because they're not really a studio, but the access points for telemedicine, and have that face-to-face conversation with that specialist in another place in Ontario. It takes care to people where they are rather than people having to travel to that care. We've heard from France Gélinas that she observes in her community there's great uptake in some areas, not so great in others. We know there's opportunity to further expand the Ontario Telemedicine Network.

The other great example is when there is an accident or some sort of brain trauma or a stroke, that scan can be read by an expert somewhere else in real time. What used to happen was the physician in the emergency department might have a telephone consult with someone else, but they would have to use words to describe the image and would have to use words to describe the patient. Now that neurosurgeon can actually see the scan for themselves and they can say, "Here's what to do." It used to be that they would always err on the side of caution and transport the patient, often unnecessarily, putting a patient and their family through an unnecessary transport and putting unnecessary pressure on our health care system.

There are many examples of how spreading the expertise using technology is exactly what we need to do to provide care for people wherever they are.

**Mr. Phil McNeely:** And that's available throughout all rural Ontario pretty well, now?

**Hon. Deborah Matthews:** Yes, I would say we have very good coverage now.

**Mr. Phil McNeely:** The ConnectingGTA—I've heard about it before and we've talked about it today, but I'd like you to go over that again, if you would. What are the benefits of that program? Why was that one sort of

pushed to the front? There are good reasons, I've heard, but I'd like to hear them again.

**Hon. Deborah Matthews:** ConnectingGTA links all of the health care providers in the five GTA LHINs. That is close to half the population of Ontario that will benefit from ConnectingGTA. If you can imagine an individual who is accessing different parts of the health care system—a hospital, maybe a second hospital or a third hospital, a community care access centre, other community supports, a range of health care providers all looking after one patient. Before ConnectingGTA, each one of those would have their own files, their own records, take their own history, would not share information from different providers. When ConnectingGTA is up and running, all of that information related to one individual will be on that one electronic database. What it means is much better continuity of care.

It's not unusual for people in the GTA to go to more than one hospital, but if all of your tests and images can be viewed by anyone in any of those other hospitals, it's just better patient care. It's faster access to care. It's a reduction of duplicate, unnecessary tests. All of that information about that individual is in one place that can be viewed by all of the people in that individual's circle of care. It makes so much more sense than having individual files unconnected for the same individual across the system.

We're very excited about this. It's a very ambitious project: 700 providers to be linked up. That work is under way now.

**Mr. Phil McNeely:** The rationale part was dollars—vying for the dollars, we hear. We have a lot of large institutions, a lot of people, and the mobility across the city. Those were the advantages that were seen and that's why we've gone in that direction. That makes sense.

**Hon. Deborah Matthews:** When I first became Minister of Health, I had a little focus group with some elderly people and I asked them to give me some advice on my first days on the job. I was surprised the one issue that they wanted to talk about the most was having an electronic health record, because they know that we can be a much more efficient system if we share that information. I think all of us look forward to the day when we have ConnectingGTA done.

I have to also say that in the Hamilton area there has been some very, very good work done there on connecting information from various providers. That information is available there. There is good work being done across the province and, step by step, we're going to get to where we all know we need to be.

**Mr. Phil McNeely:** I sat on public accounts back three or four years ago when we were looking into eHealth. I found it an extremely interesting exercise. There were many difficulties, but building that platform was the problem. You built the platform but you got no use out of it. We've come a long way since then. Now you're looking at the next 30 months, 2012 up to 2015—36 months is when you will see probably substantial completion of the project?

**Hon. Deborah Matthews:** I would say that we're never going to be done. There will always be new technology, there will always be better ways to do it, but that goal of an EMR for every Ontarian by 2015 is within sight. And then, the linkages between providers is the next frontier. Some of that is happening now, but having that EMR by 2015 is where we're going.

We can't do it alone. We can't dictate to family doctors that they have an EMR—at least, we don't do that now. We need to work with them to make sure it works for those doctors to convert their patient records to electronic health records.

1550

**Mr. Phil McNeely:** The other issue that we covered when I was on public accounts before and was interesting to me was the safety of patients and C. difficile. I understand that there's new information out on the successes that the hospitals have had. Could you go through that?

**Hon. Deborah Matthews:** I'm very happy that you've raised this issue. ICES has just released a report that looks at C. difficile in our hospitals. We have seen over the past three years, I believe, a 28% reduction—have I got that right?—in the number of cases of C. difficile in our hospitals. That's extraordinary improvement, close to 2,000 fewer cases than we had just a few years ago. There is no question in my mind that we have made progress because we have been publicly reporting this information. It goes back to the transparency. If we measure and if we publicly report, we can actually begin to drive change.

When it comes to C. difficile, it requires the co-operation and the engagement of everyone in the health care organization. It's not just a decision that's made at the upper echelons; it's everybody, every single person working in that hospital, regardless of their role in the hospital; every visitor, every patient. We all have a role to play when it comes to reducing the spread of infectious diseases.

One case of C. difficile is one too many, but we've made remarkable progress because people in hospitals have embraced this quality improvement initiative. I'm just enormously proud of our health care workers in our hospitals who have taken on the best practice of washing their hands. Often, it's as simple as that hand hygiene.

We've now got quality indicators. All of our hospitals have quality improvement plans. They choose the indicators, they set the goals. Many of them chose hand hygiene compliance as one of their priority areas in the first year of the implementation of the Excellent Care for All Act.

**Mr. Phil McNeely:** How much time left, Mr. Chair?

**The Chair (Mr. Michael Prue):** I am not exactly sure, but I think somewhere around 4 of the clock is when we're done. The clerk is not here, so I'm trying to keep it the best I can.

**Mr. Phil McNeely:** One of the areas we didn't cover in here was my mistake. I took you to the demographic challenge, which was very interesting, but the statistical challenge—if you could just tell us about the co-

operation we need from all the workers across Ontario, but specifically in your own ministry.

**Hon. Deborah Matthews:** As you know, our government has a plan to get to balance over five years. We have set, as a government, that priority. We will protect those core services that matter the most to Ontarians. We're protecting health care, we're protecting education, we're protecting social services. But even though we're protecting those areas, the rate of growth will be less than what we've become used to. Because we have significantly increased spending at a rate of over 6% a year since we came to office, we now are at a place where I think, when we all work together, we can achieve better value for money. With that additional spending, we can invest in those priority areas. Other parts of the health care system are going to have to work hard to do better to find efficiencies within.

I have to say that people in the health care sector have embraced this challenge. You've heard of the concept of disruptive change. If you just keep going on and on, year over year, increase, increase, increase, people don't tend to step back and say, "What do we need to change from a system perspective?" Now they're having to do that, and it's a beautiful thing to watch people in the health care system accepting our reality. They know that they've done well in the past, and now is the time to really drive best value for money.

Overwhelmingly, people in health care are looking at ways that they can be part of this change. At the end of the day, we're going to have a better health care system, we're going to have it better for patients, smoother for patients, easier access to health care for patients, and we're going to be fiscally responsible as well.

**Mr. Phil McNeely:** Home care is an exception to the rule of not having increases. How much more is going to be placed there, and what are going to be the results of that?

**Hon. Deborah Matthews:** Because we're holding other parts of the health care system steady, we're able to invest an additional 4% a year in the home and community care sector. We have given the responsibility to the LHINs to allocate that money based on very clear criteria.

The number one issue for me is ALC. When we have a patient in a hospital who shouldn't be there, who doesn't need to be there, who doesn't want to be there but is there because there is not capacity outside hospital, I know we haven't got our system in balance. Getting people the right care in the right place at the right time is our highest priority, and we're seeing some tremendous success stories. My home hospital, London Health Sciences Centre, has seen their ALC rate cut in half since they instituted Home First. These changes are happening, and it's enormously exciting.

**Mr. Phil McNeely:** I was at a meeting with Alex Munter at one time, and he asked the question—there were 600 seniors in the room—"Who wants to go to long-term care?" Of course, no one did. Obviously, that is the right way.

I mentioned something about nurse practitioners earlier today, that I was very impressed with what they were doing and where you're going. I would just like your comments on nurse practitioner-led clinics—the family health teams and the clinics.

**Hon. Deborah Matthews:** You know you're doing something right when you go outside of Ontario and people are asking about one particular part of the health care system change. I can tell you, when I meet with health ministers from across Canada, one thing they all want to talk about is our experience with nurse practitioners.

We've now got over 1,000 nurse practitioners working in Ontario, some of them in primary care, some of them in hospitals, some of them in long-term-care homes—different settings. These are our nurses who have gone back to upgrade their training, and many of them specialize in a particular part of the health care system. They're providing superb care and very much enjoying the experience.

There's enormous ability amongst our health care providers. Giving people the opportunity to work to their full scope of practice, giving them opportunities to develop new skills is an important part of strengthening our health care system.

**Mr. Phil McNeely:** Mr. Chair, I'm finished with my questions.

**The Chair (Mr. Michael Prue):** Any other questions from the Liberals? We do have two and a half minutes.

**Mr. Kim Craitor:** Great. Thanks.

I have one short question, Minister, and it's about something I know you're very familiar with: the Niagara Health System. I can still remember, before I was elected as a provincial member of Parliament, the previous government thought the way to improve health care in the Niagara region was to amalgamate all the hospitals, create a single health care system, and off they went. In the last five or six years, I have expressed my concerns that that system that was put in place by the previous government wasn't working.

What you have done—and I just wanted you to give a bit of an update, and this is a great place to do it—is you did bring in a supervisor, which I had been pushing for, just to look at this organization called the Niagara Health System to see if there was a way we could improve it, to see if it could actually function the way it was set up. I was just wondering if you could give us an update on where we are with that review by Kevin Smith, who you've brought in to do that—and I thank you for that.

**Hon. Deborah Matthews:** I want to thank you for your advocacy on that issue.

As you know, we did send in a supervisor—it'll be close to a year ago now; 10 months, maybe? The reason we sent in a supervisor—every case is different. As you know, this one was difficult because on some measures they were doing fine, but we kept hearing that the community had lost confidence in the organization. Kevin went in and he listened. What he did for the first several months is he went out and listened to staff, to members

of the community. He really wrapped his head around what was going on there, made some big changes initially—much stronger support for patients who have complaints and challenges in the NHS—has started to really rebuild the confidence of people there.

**1600**

He put out a report—a report to the community, not to me—reflecting what he has heard, with some options on moving forward. Right now, we're in that phase where we're looking to the community to respond to that report. I know this is not easy, the questions that he has put to the community, because his recommended option does involve the closure of some hospitals but the building of a brand new one.

I don't have a preconceived notion on what the way forward is, but I know that in your community, in the Niagara area, people know what they want, and we will make sure that they get excellent care and that they will have confidence in the care they receive.

**The Chair (Mr. Michael Prue):** With that, we're going to stop you. We're going to go to the lightning round: 10 minutes each.

**Mr. Rob Leone:** The lightning round.

**The Chair (Mr. Michael Prue):** I'm going to stop you exactly on the second, because we do have to stop on time. You've got 10 minutes each, starting now with the Conservatives.

**Mr. Michael Harris:** Thank you. To the minister or deputy minister: Can you provide to us the total number of employees employed at the Ministry of Health? You can just table that for us, I guess.

**Mr. Saäd Rafi:** Sure.

**Mr. Michael Harris:** Okay, thank you.

**Mr. Rob Leone:** Do you know the number?

**Mr. Saäd Rafi:** Approximately 3,680.

**Mr. Michael Harris:** Okay, if you can table that, that would be great.

**Hon. Deborah Matthews:** And we'd be happy to table it over time too, because I think you'll see the number—

**Mr. Michael Harris:** Sure, sure.

I want to come back to my line of questioning with regard to the Niagara ambulance communications pilot. You may need to call your assistant deputy minister back. I will give you a second chance to correct the record. My line of questioning is, again, to the minister or deputy minister or the assistant deputy minister. Who commissioned the report called the evaluation of the Niagara ambulance communications pilot?

**Ms. Patricia Li:** The report, as I understand, was commissioned as a joint effort between the ministry and the Niagara dispatch, which is the EMS system in Niagara—

**Mr. Michael Harris:** So who paid—

**Ms. Patricia Li:** —so it's a jointly owned report.

**Mr. Michael Harris:** Who paid for this report?

**Ms. Patricia Li:** I don't know exactly who paid for the report. I would say that because Niagara EMS re-

ceives funding from the ministry, they would use that funding to pay for the report.

**Mr. Michael Harris:** Yes. Assistant Deputy, I just got off the phone with a high-ranking official at the region of Niagara and they've not seen this report. I believe PricewaterhouseCoopers was commissioned to perform this report and this would have been commissioned by the ministry. I need you to inform the committee who commissioned this report and—well, who paid for it, I guess.

**Ms. Patricia Li:** The report, as I already said, was commissioned as a joint report by the region of Niagara and also the ministry. I actually can assure you that the Niagara region has seen the report, because I met with the chief medical officer of health in the Niagara region in 2010 and we discussed the joint report when it was in draft form, so they must have seen the report.

**Mr. Michael Harris:** All right. Again, I've got a motion that I'm going to be bringing up, following this committee, and I'll ask the minister or deputy, prior to us getting to this, if you will table that report in full, unredacted, unsevered, to this committee as per standing order 110(b), no later than August 13, 2012. Deputy?

**Mr. Saäd Rafi:** Sorry; you said you were going to table a motion after this—

**Mr. Michael Harris:** I'm asking you if you will provide the report to this committee by August 13, 2012. The report has been done; it has been commissioned; it's sitting on a shelf. It was done, what, in 2005, 2010—in 2010?

**Ms. Patricia Li:** It was to be done in 2010, because that's when the pilot finished.

**Mr. Michael Harris:** Okay, so it's about two years old. I'm assuming it wouldn't take too long to print off and forward to this committee. Will you forward it to this committee by August 13?

**Mr. Saäd Rafi:** It's my understanding the committee has the ability to ask for any information, and—I have to acquaint myself with the estimates committee—you have certain rules you've agreed to as to what's in scope and not. As the minister said, we'll certainly look at that and then respond to that request.

**Mr. Michael Harris:** Will you also table any costs or fees, including consulting fees, associated with both the preliminary report and the report itself?

**Mr. Saäd Rafi:** Same answer.

**Mr. Michael Harris:** Okay, thank you for that. I don't know if you have anything else, Rob.

Again, Minister, you had stated that you had never read the report at all.

**Hon. Deborah Matthews:** No. I'm aware of it and I've been briefed on parts of it, but I've not read it myself.

**Mr. Michael Harris:** Were you briefed to the extent that the report actually entails efficiencies in the system and overall benefits that would save lives and reduce overall costs? Should municipalities operate the dispatching system as similar to the region of Niagara?

**Hon. Deborah Matthews:** I would be careful that—I think you're speculating on what the results of that report are.

**Mr. Michael Harris:** That's why I'm asking, Minister, because you've been briefed on the report. I'm simply asking you if that report contains information that would assist in efficiencies in both cost and timely access to ambulance service. I would not want to speculate anymore by having you provide that answer to me.

**Hon. Deborah Matthews:** What we've said is we'll undertake to, if possible, get that report to you, and rather than speculating on the content of it, you can actually read it for yourself.

**Mr. Michael Harris:** Thank you.

**Hon. Deborah Matthews:** But I am going to ask you if you would share the name of the high-ranking official in Niagara region who you were quoting, because I think it's important that we ensure—

**Mr. Michael Harris:** No, I don't think it's important. What's important is that this committee gains access to that report, as I had mentioned before, and that the assistant deputy minister stated that it was commissioned by the region, which is wasn't; it was a ministry report. I just want to fact-check on that part of it first.

**Mr. Saād Rafi:** Just a point of correction: I think we said "jointly commissioned" by the region and the ministry, just to be clear, not just by the region.

**Mr. Rob Leone:** I think we're all trying to rethink what we heard, given the long day that we had here, but I think the original reason why we've come back to this question was because it was previously stated that this was a Niagara region report. Now we're hearing that it's a joint effort, and I think that's the discrepancy that we want to pull out, because we obviously have a discrepancy in what I understood to be what the assistant deputy minister had stated. We need some clarity.

I think this is a very important report. There are people in the Niagara region who haven't seen the details of a report that talks about how to make their system more effective. Ultimately, that impacts patients, and that's what we're concerned about. We're concerned about better service delivery for patients. That's why we want to see the report. That's the importance of it.

**Ms. Patricia Li:** I would like to clarify that point. As part of the pilot project, one of the conditions is to have an evaluation of the pilot project after it was completed, which was in 2010. PWC did do that report as consulting services.

The report is commissioned by the ministry, but the result is jointly owned by the ministry and the Niagara region.

**Mr. Michael Harris:** So the region will have this report.

**Ms. Patricia Li:** They do have this because I met with them. I met with the chief medical officer of health. I met with the EMS chief. They both have that report.

**Mr. Michael Harris:** So the region should be able to provide us that report as well, to any one public member that should ask for it.

**Ms. Patricia Li:** If they agree to.

**Mr. Michael Harris:** Why then do I have a letter signed by Patricia McQuade from AMEMSO asking for this report, that 25% of it would be severed at some cost that would exceed \$1,000? Why, if this report is so readily available, did your ministry send a letter to the association asking them to comply with an FOI? Why is that necessary?

**Ms. Patricia Li:** I don't know about the particular letter you're referring to, but I can only assume that's because the ministry has an obligation to report back to cabinet as part of the conclusion of the pilot project and we haven't done that.

**Mr. Michael Harris:** The report has been done for two years and you've not reported back to cabinet yet?

**Ms. Patricia Li:** Yes.

**Mr. Michael Harris:** Two years.

**Mr. Rob Leone:** What effect does that have? Again, our concern is for patients in Niagara. It's for patients in Waterloo region. It's for patients in other communities that this is going to affect. Don't you think that a delay of two years negatively affects patients in general? Doesn't that delay frighten you?

1610

**Mr. Michael Harris:** Especially when there are calls from other municipalities across the province? London, the area that you represent, Minister; Peel, York, Waterloo region—when they're calling for regional control or regional operations of the dispatch to help increase the likelihood of saving lives in terms of response times, efficiencies, why a two-year delay?

**Ms. Patricia Li:** First of all, I'd just like to summarize what the report is all about. As I said earlier, the project—

**Mr. Rob Leone:** Do you have a copy of the report?

**Ms. Patricia Li:** Yes.

**Mr. Rob Leone:** Okay.

**Ms. Patricia Li:** That's why we can respond to you with respect to the data.

**Mr. Michael Harris:** But the minister already said that—well, she's been briefed on it.

**Ms. Patricia Li:** She doesn't have it.

**Mr. Michael Harris:** She doesn't have a copy of the report. Okay.

**Ms. Patricia Li:** The pilot project is on the technology improvement to the dispatch within the Niagara region, to implement a separate technology, which is separate from the 22 dispatch centres currently in ambulance dispatch, other than Toronto. So I think the pilot, as I can understand it because it is before my time, is to test a new technology and see if it works in Niagara. Five years—

**Mr. Michael Harris:** I thought the technology was to evaluate the program—

**The Chair (Mr. Michael Prue):** I'm sorry, that's the 10 minutes. I told you it would be right on the dot.

NDP?

**M<sup>me</sup> France Gélinas:** I'll speak very fast. The first is on page 141. It was a little question from the briefing book. It basically talks about "Payment for ambulance

and related emergency services: municipal ambulance,” then, “Payment for ambulance and related emergency services: other ambulance operations and related emergency services.”

I understand fully what municipal ambulances are. I’m not too sure who’s included in the second line.

**Ms. Patricia Li:** Are you referring to the \$64 million?

**M<sup>me</sup> France Gélinas:** Yes, I am.

**Ms. Patricia Li:** Okay. The \$64 million is divided into a number of separate components. There is \$14.9 million for base hospitals, \$13.9 million for First Nations, and then we have a number of dispatch centres which we operate under a transfer payment relationship, which is \$15.2 million. There’s \$13.8 million for the critical care land ambulance system, which is run currently by Ornge. Then, the rest of it is just miscellaneous relating to workload increase for the dispatch, which is around \$6.6 million.

**M<sup>me</sup> France Gélinas:** Thank you. And I take it that the last one, which, Deputy Rafi, you had started to give me an answer to—that was the one on page 135—I will get the list of what makes up the \$2.6-billion priority programs?

**Mr. Saäd Rafi:** Yes, and just generally, or quickly, about \$1.4 million to \$1.8 million is dispensed by the LHINs for either hospitals, community care access and other related activities. We have some PCOP money in there. We would have acquired brain injury programs; some money for assisted living and supportive housing perhaps. So it’s an amalgam of funds, but the bulk of those funds are at the discretion of the LHINs and dispensed by them.

**M<sup>me</sup> France Gélinas:** To the tune of \$1.4 million, I think you said.

**Mr. Saäd Rafi:** Yes, \$1.4 million to \$1.8 million. I’m trying to remember actual—

**M<sup>me</sup> France Gélinas:** Okay. You will give me the exact numbers that go with—

**Mr. Saäd Rafi:** Yes.

**M<sup>me</sup> France Gélinas:** Okay, very good.

My next question—I’m going back a little bit on home care—has to do with something that’s happening in the northeast. Right now, allied health professionals—physiotherapists, occupational therapists etc.—contract directly with the CCAC and they offer services in all sorts of little areas in the northeast. They have all been advised that the CCAC will not be renewing their contract. They want those people to basically be employees of existing service providers. They have put to them six rehabilitation service providers. Five of them are for-profit, one is a not-for-profit and none of them are in northern Ontario.

Physiotherapists are hard to find in my neck of the woods. Now they are being forced to contract with southern service providers so that they can have a contract with their CCAC—and guess what?—for less money. I’m not too happy with what’s going on. I was wondering if it was government policies that told our CCAC that they could not have direct contracts with health providers

or if this is something that my local CCAC has decided to do.

**Hon. Deborah Matthews:** We’re not aware that this is something that has been directed from the ministry. I would be happy to get more information on this initiative by the CCAC in the northeast.

Are we talking about designated physiotherapy clinics?

**M<sup>me</sup> France Gélinas:** No, no. It’s a physiotherapist who does work for CCAC. He does home care work for CCAC in—

**Hon. Deborah Matthews:** And they’re individual, sole providers?

**M<sup>me</sup> France Gélinas:** Correct.

**Hon. Deborah Matthews:** We’d be more than happy to look into the details on that.

**M<sup>me</sup> France Gélinas:** Okay. And you will let us know?

**Hon. Deborah Matthews:** Yes.

**M<sup>me</sup> France Gélinas:** My next question has to do with hep C. We have the people who are pre-1986 and post-1990 who have been compensated for, the blood-tainted victims—

**Hon. Deborah Matthews:** Tainted blood?

**M<sup>me</sup> France Gélinas:** Yes—but the pre-1986 and post-1990s have not been compensated to the same amount as the 1986 to 1990 victims have. Is there any intention or work being done at the ministry level to equally compensate the pre-1986, post-1990 victims?

**Hon. Deborah Matthews:** Perhaps you could just tell me, is this through Canadian Blood Services?

**M<sup>me</sup> France Gélinas:** Yes, it is. Well, what used to be Red Cross.

**Mr. Saäd Rafi:** I would have to consult with Canadian Blood Services as to what’s taking place there. Specifically in Ontario, of course, you’re talking about?

**M<sup>me</sup> France Gélinas:** Oh, yes, specifically—solely in Ontario, because the Ministry of Health has received funding and has compensated those victims. They just have not compensated equally to the ones who got compensated for 1986-90, who got a certain amount; pre-1986, post-1990 got a different amount.

**Hon. Deborah Matthews:** We’ll look into that.

**M<sup>me</sup> France Gélinas:** Okay. My next question has to do with the review of the Healing Arts Radiation Protection Act, HARP as it’s better known. Which experts in radiation safety and relevant stakeholders will be involved in the review of this act? Any idea if this is coming anytime soon?

**Hon. Deborah Matthews:** Yes, in fact, it is. We are committed to reviewing the HARP Act.

**M<sup>me</sup> France Gélinas:** Who will the stakeholders be who are chosen to work on this?

**Hon. Deborah Matthews:** It’s not been determined yet, but it’s on our plan to take a look. There have certainly been many advocating that it does need a fresh look. Reza Moridi, MPP, is one of the strongest proponents for—

**M<sup>me</sup> France Gélinas:** The review? Okay. If there's a way for people to let the ministry know that they are interested in taking part in this review or they are interested in giving input into this review, how would they go about doing that?

**Hon. Deborah Matthews:** They could notify the ministry.

**M<sup>me</sup> France Gélinas:** Directly?

**Hon. Deborah Matthews:** Yes.

**M<sup>me</sup> France Gélinas:** My next one—they're all odd ones. Family Service Ontario has submitted to you a proposal called Walk-In Counselling Clinics: A Powerful Relief Valve for Pressure on Ontario's Health Care System. They have piloted a few walk-in clinics for counselling services. They have submitted their review and proposal to you, and I was wondering if your ministry is still interested in walk-in counselling clinics. If your ministry is still interested, when can we expect a response to their proposal?

**Hon. Deborah Matthews:** This is a proposal I'm quite familiar with. Family Service Ontario was here at Queen's Park not too long ago advocating for that funding, and it's something that we're looking at.

I am impressed with the results that they've been able to demonstrate in those pilots. I can't make any commitment other than that we will look seriously at that request.

**M<sup>me</sup> France Gélinas:** All right. When I was talking about some of the transitional college councils, one group that is particularly unhappy is the naturopathic doctors, just to flag it. You've offered a briefing, so when I find out more, they are on my radar as one that is not happy with their relationship with the ministry.

1620

My other questions—I'm coming back to long-term care. On an annual basis, you change how much money people pay for a standard etc.

**Hon. Deborah Matthews:** Yes.

**M<sup>me</sup> France Gélinas:** And this year, for the first time, you have brought in differential fees for older homes, to recognize, I guess, that older homes—is this something that you intend to pursue further as the difference between new homes and older homes—that get older and older—continues as the years go by?

**Hon. Deborah Matthews:** You know that we are engaged in a process to redevelop all the older homes, 35,000—

**M<sup>me</sup> France Gélinas:** Yes, I am. They're like turtles getting in line.

**Hon. Deborah Matthews:** And we're hoping to accelerate the turtles, because there are some homes that are not attractive for people who want to go into long-term care, so as a result we have several hundred empty beds in homes that are just not appealing.

**The Chair (Mr. Michael Prue):** Okay, that will be the 10 minutes right to the dot. Liberals, final 10 minutes.

**Mr. Phil McNeely:** I thought it was over with the last group of questions. It has been a long, long day.

I know there have been a lot of negatives in the past, but you showed us there are so many positives from where we are with health care. Certainly, the one that—I waited a couple of years for a new knee back in 2003. I got it, I think, just after I became an MPP. It had nothing to do with it, but that two-and-a-half-year wait finally came up. To have gone from the worst in Canada to the first for wait times for many procedures—I think that should be said much more often.

It's like I talk about us getting out of coal in Ontario. It's so very important. It's the first government that I know of, at least, that's getting out of coal. It's so important, and it was done for health reasons.

I think that you deserve the time now to say what you want and not respond to questions, so if you would take the last seven or eight minutes on our behalf, I'd appreciate that, Minister.

**Hon. Deborah Matthews:** Thank you. We really have made tremendous progress over the past nine years when it comes to health care. There are many ingredients to that success. Certainly, we have spent more money on health care, significantly more money, and that has allowed us to rebuild the foundation of our health care system: more people with family doctors; shorter wait times; significantly enhanced use of technology. There's a lot that is happening.

We know there's more to do and we will always be looking at what is the next thing that needs to be done. But I think taking the time every now and then to really acknowledge the progress that has been made is important. It's an opportunity for me to say thank you to all of the people in the ministry, throughout our whole health care system, who have worked very, very hard to drive the change that is positively impacting the delivery of health care in this province.

Change is difficult, but our extraordinary partners in health care have demonstrated that, given the right tools, we can make remarkable change together.

A very important part of the change we've been able to drive is our commitment to transparency. When you were waiting on that list for your knee replacement, nobody knew how long those wait times were. Every provider kept their own list, and there was no one who was actually monitoring how long those wait-lists were. We've gone from not even measuring, and everyone keeping their own list, to now publicly reporting. Anybody can go online and see what those wait times are, by hospital, for key procedures. I can't underline enough how important it is that transparency around information really can drive change.

Wait times: As I said earlier, we know we're meeting our targets on almost all of our surgical wait times. We know we still have challenges in some areas, some individual hospitals. There's always an explanation—you know, somebody retired and they didn't replace—there's a reason, but only when you see those numbers can you actually drive change.

I think the Excellent Care for All Act that was passed by our government—some people have described it as,

perhaps, the most important single piece of health care legislation since the introduction of universal health care because it turns the attention on quality. Hospital boards have big responsibilities. We entrust a lot to those hospital board members, but we've never given them the tools they need on the quality front. They've had responsibility on the financial side, and they take that responsibility seriously. Now they are taking the issue of quality seriously. Those hospital boards have identified their quality improvement initiatives. We've now tied executive compensation to the achievement of those quality improvement indicators.

When I talk about quality of care, sometimes people don't really know quite what that means, but it means getting patients the highest possible quality care. That means lower infection rates; that means fewer hospital readmissions; that means fewer medication errors. There are quality indicators that result in better patient care, and we need to manage quality; it can't be just a by-product that we just assume is there in our hospitals. When hospitals now can compare how they're doing on a range of safety indicators with how other hospitals are doing, that really does drive change.

We are so blessed in this province to have the doctors that we have, to have the nurses that we have. All of our health care providers, our personal support workers, our mental health workers, people who work in the cleaning staff in our hospitals—everybody wants to be part of providing excellent patient care. We're getting there. We're not there yet, but we are continually improving the quality of care, we're driving better value for money. Our hospitals: You heard earlier today that the vast majority of hospitals are now in a balanced budget or even a surplus, and all of our hospitals, if they're not in balance now, have a plan to get to balance. They're being fiscally responsible. They're improving outcomes for patients. But I am seeing those silos coming down in our health care system now. People are working together in a way that amazes even them.

I'm particularly excited about our seniors strategy. I was at a meeting with Dr. Sinha last week and brought together several providers in the Toronto Central LHIN, including EMS, including public health, including hospitals and home care—all of the providers in one room talking about, "How can we wrap care around an individual? How can we work better together as we move forward?"

There's excellent work that's happening out there. I'm inspired by the people who work in health care. It's a true honour for me to lead the Ministry of Health and to drive that change. I think that this is an important exercise that we go through every year. I think it's important that MPPs do their due diligence. You are holding me and my ministry to account, and that's an important job of elected representatives.

I want to say a particular thank you to France for raising issues that are thoughtful, that are focused, that demonstrate to me that you are interested in actually improving outcomes for patients. That has been the

attitude you've brought to your position as critic, and I'm grateful for that.

**M<sup>me</sup> France Gélinas:** Well, thank you.

**Hon. Deborah Matthews:** We all have a role to play, regardless of what side of the House we sit on, in improving patient care. We all have constituency offices. We all meet with people in our ridings who are asking more of us, and I think it's our responsibility to deliver that more. We can't do it all at once, but we do need to do it in a step-by-step manner, where we are transparent about the outcomes, where we measure the results. We can't afford anymore to do things because we think they might help. We need to have demonstrated outcomes that come from our investments.

**1630**

I'm very excited about the action plan. It has received tremendous support. I know you were with me in Sudbury when I presented at a high level the elements of the action plan. People who work in health care say that we've hit the right elements to take the system to the next level. It's going to be a lot of work in implementing that. We've had an opportunity to talk about some of those elements today. We will continue to drive forward. It's an ambitious plan, but it's exactly what we need to do.

I'm excited about the future. I'm proud of the accomplishments to date. There are always bumps in the road. It's never perfect, but it is very, very good. The people we serve are getting better health care today than they were nine years ago—significantly better health care now than they were—because of the change that has been supported by the ministry but delivered by people on the front lines.

**The Chair (Mr. Michael Prue):** I thank you very much.

We have a point of order. Mr. Harris?

**Mr. Michael Harris:** Chair, I'd like to introduce a motion.

**The Chair (Mr. Michael Prue):** You cannot.

**Mr. Michael Harris:** Chair, I'd like to simply introduce a motion. The government and the minister already said that they would table documents, but I'd like to make it official and seek unanimous consent.

**The Chair (Mr. Michael Prue):** Okay. If you wish unanimous consent, then anything can be done. Could you please read out what you want to do?

**Mr. Michael Harris:** Sure. That the Standing Committee on Estimates—

**Mr. Phil McNeely:** Mr. Chair, I think that we've had a long day. There has been nothing to inform us of this. I think—

**The Chair (Mr. Michael Prue):** After he reads it, all you have—

**Mr. Michael Harris:** That the Standing Committee on Estimates—

**The Chair (Mr. Michael Prue):** Excuse me, the clerk has reminded me—and I'm sorry, I'm getting ahead of myself—that the estimates must come first. After the votes on estimates, you may seek unanimous consent for

what you wish. I will recognize you before we move on to the next ministry.

We're going to vote first, because the rules are that we must proceed immediately to the vote. We're going to hold the vote—there's a series of 12 votes to be held—and then I will recognize Mr. Harris. He requires unanimous consent. You can hear him out. You can either vote yes or no as you see fit.

We're going to proceed now to the votes. Just so that everyone has a pretty clear idea—yes, Mr. Harris?

**Mr. Michael Harris:** I'd just like it to be—what is it?

**Mr. Rob Leone:** A recorded vote.

**Mr. Michael Harris:** Sorry, a recorded vote on all 12.

**The Chair (Mr. Michael Prue):** On all 12. Okay. Just for the ease of members, I think the easiest way to follow this is if you turn to 279 of your large book, if you have it with you. You don't need to have it—I will read it out anyway—but there is a series of 12 votes, and this helps to make it easier understanding how we go.

The first vote is on the ministry administration program, number 1401. Shall 1401 carry?

**Ayes**

Crack, Craitor, Dhillon, McNeely.

**Nays**

Harris, Leone, Nicholls.

**The Chair (Mr. Michael Prue):** That carries.

Vote 1402 is the health policy and research program. Shall 1402 carry?

**Ayes**

Crack, Craitor, Dhillon, McNeely.

**Nays**

Harris, Leone, Nicholls.

**The Chair (Mr. Michael Prue):** That carries.

Vote 1403 is the eHealth and information management program. Shall 1403 carry?

**Ayes**

Crack, Craitor, Dhillon, McNeely.

**Nays**

Harris, Leone, Nicholls.

**The Chair (Mr. Michael Prue):** That carries.

Vote 1405 is the Ontario health insurance program. Shall 1405 carry?

**Ayes**

Crack, Craitor, Dhillon, McNeely.

**The Chair (Mr. Michael Prue):** That carries.

Vote 1406 is the public health program. Shall 1406 carry?

**Ayes**

Crack, Craitor, Dhillon, McNeely.

**The Chair (Mr. Michael Prue):** That carries.

Vote 1407 is deferred because it's not on the first page, but it does come up later.

Vote 1411 is the local health integration networks and related health service providers. Shall 1411 carry?

**Ayes**

Crack, Craitor, Dhillon, McNeely.

**Nays**

Harris, Leone, Nicholls.

**The Chair (Mr. Michael Prue):** Carried.

Vote 1412 is related to the provincial programs and stewardship. Shall 1412 carry?

**Ayes**

Crack, Craitor, Dhillon, McNeely.

**Nays**

Harris.

**The Chair (Mr. Michael Prue):** That carries.

Vote 1413 is the information systems. Shall 1413 carry?

**Ayes**

Crack, Craitor, Dhillon, McNeely.

**The Chair (Mr. Michael Prue):** That carries.

Vote 1414 is health promotion. Shall 1414 carry?

**Ayes**

Crack, Craitor, Dhillon, McNeely.

**The Chair (Mr. Michael Prue):** That carries.

Back to 1407, which you will see for the first time recorded on page 281; it's the health capital program. Shall 1407 carry?

**Ayes**

Crack, Craitor, Dhillon, McNeely.

**The Chair (Mr. Michael Prue):** That carries.

Shall the 2012-13 estimates of the Ministry of Health and Long-Term Care carry?

**Ayes**

Crack, Craitor, Dhillon, McNeely.

**The Chair (Mr. Michael Prue):** That carries.

Shall I report the 2012-13 estimates of the Ministry of Health and Long-Term Care to the House?

**Ayes**

Crack, Craitor, Dhillon, Gélinas, McNeely.

**The Chair (Mr. Michael Prue):** That carries.

That completes our consideration of the estimates of the Ministry of Health and Long-Term Care.

I now recognize Mr. Harris.

**Mr. Michael Harris:** I'm simply asking for unanimous consent to hear my motion that states that the Standing Committee on Estimates, herein "the committee," under standing order 110(b), stating that "each committee shall have power to send for persons, papers and things," directs the Minister of Health as well as the Ministry of Health and Long-Term Care to produce, no later than August 13, 2012, all documentation, electronic or otherwise, related to the evaluation of the Niagara ambulance communications pilot, including the full report in its unsevered, unredacted entirety.

**The Chair (Mr. Michael Prue):** Is there unanimous consent?

**Interjection:** No.

**The Chair (Mr. Michael Prue):** Unanimous consent not being forthwith, I cannot entertain it.

**Mr. Rob Leone:** Point of order, Mr. Chair: I would like to state also that this is information that the minister has agreed to provide the committee. We just want to isolate that and put it in a motion so that we can—

**Mr. Michael Harris:** Crystallize it, as Minister Duncan would say.

**Mr. Rob Leone:** —crystallize it, so that we can actually have this information put forward on the committee. It seems to me that the Liberal members, particularly Mr. McNeely, Mr. Dhillon, Mr. Craitor and Mr. Crack, are somehow not aligning with their minister's wishes with respect to releasing this document—

**The Chair (Mr. Michael Prue):** No, I don't think one can say that.

**Mr. Vic Dhillon:** It's not a point of order.

**The Chair (Mr. Michael Prue):** First of all, it's not a point of order. It requires unanimous consent. The minister and the deputy minister have already stated many times that they will release this information. I think we

are obligated to take them on their word, and perhaps that was part of the rationale for the honourable members voting as they did, but I don't think you can question the motive for why they did what they did. The documents, I am assured, are forthcoming, and that has been stated here over and over.

**Mr. Kim Craitor:** Point of order?

**The Chair (Mr. Michael Prue):** On a point of order.

**Mr. Kim Craitor:** Since my name was mentioned and in some unique way you've come to the conclusion that I'm opposed to this without me saying anything—and only because of that; otherwise I would not have said anything, but my name has been mentioned with these motives—I would have supported that. It's the Niagara region; I represent the Niagara region. I was there when we funded the creation of that new delivery model because the public demanded it from us. I don't have a problem with that.

The only reason I'm mentioning it is because I want to put into the record, with the greatest respect to Rob, that, no, I would have supported that. I see nothing wrong with releasing something like that to the public, particularly for the area that I represent.

**The Chair (Mr. Michael Prue):** In any event, it required unanimous consent and unanimous consent was not forthcoming. I think the issue is finished.

Is there any other business before the committee before we go on to the ministry of francophone affairs?

**Mr. Rob Leone:** I do, Mr. Chair. I would also like to seek unanimous consent to present the following motion:

That the Standing Committee on Estimates, under standing order 110(b), stating that "each committee shall have power to send for persons, papers and things," directs the Minister of Health as well as the Ministry of Health and Long-Term Care to produce no later than August 29, 2012, the Minister of Health and Long-Term Care's House book, all correspondence, electronic or otherwise, related to Ornge sent or received by the Minister of Health and Long-Term Care's political and bureaucratic staff and staff in the Premier's office, and all correspondence, electronic or otherwise, sent or received by the minister's political staff related to eHealth Ontario between July 18, 2012, and July 23, 2012.

**Mr. Vic Dhillon:** Point of order, Chair.

**Mr. Michael Harris:** Wait until he's done.

**Mr. Vic Dhillon:** No.

**The Chair (Mr. Michael Prue):** Wait until he's done. Please continue.

**Mr. Rob Leone:** I've finished.

**The Chair (Mr. Michael Prue):** Okay, he's finished. Mr. Dhillon, you have a point of order. I'm going to ask for unanimous consent. I have to ask for unanimous consent.

**Interjection:** No.

**The Chair (Mr. Michael Prue):** First, I'm not sure what you're saying no to, so I have to ask the question. Is there unanimous consent for this motion?

**Mr. Phil McNeely:** No.

**The Chair (Mr. Michael Prue):** There is not unanimous consent.

**Mr. Rick Nicholls:** Why?

**The Chair (Mr. Michael Prue):** They don't have to justify the reason. They do not have to justify.

Is there any other business before this committee on this ministry? Seeing none, that completes our consideration of the estimates of the Ministry of Health and Long-Term Care. We thank the minister, the deputy and all those who have been here yesterday and all day today.

**Hon. Deborah Matthews:** Thank you very much.

*Interjection.*

**The Chair (Mr. Michael Prue):** If the members wish a recess, you have to ask for it.

**Mr. Michael Harris:** Yes, I'd like to ask for a 15-minute recess.

**Mr. Grant Crack:** That's fair.

**The Chair (Mr. Michael Prue):** If there's a request for a 15-minute recess, then I'm going to tell the minister of francophone affairs that she ought not to remain because there will be—

*Interjection.*

**Mr. Michael Harris:** So did we.

**The Chair (Mr. Michael Prue):** We finish at 5. Is it the desire of this committee that we take a 15-minute recess, which is, in effect, adjourning for the day?

*Interjections.*

**Mr. Michael Harris:** I'll withdraw that recess, then, if—

**The Chair (Mr. Michael Prue):** Okay. We have a request to withdraw that—

**Mr. Michael Harris:** Yes, if the minister has come from afar, we will gladly entertain what she has to say.

**The Chair (Mr. Michael Prue):** Mr. Crack is indicating he might be interested in a five-minute recess.

**Mr. Grant Crack:** Or two, just so I can run.

**M<sup>me</sup> France Gélinas:** Can we go while you run?

**The Chair (Mr. Michael Prue):** Mr. Crack is requesting a two- or three-minute recess. Is that—

**Interjection:** Yes.

**The Chair (Mr. Michael Prue):** All right, we are recessed for two or three minutes. That will also afford the minister an opportunity to acquaint herself here in the room.

*The committee recessed from 1643 to 1649.*

## OFFICE DES AFFAIRES FRANCOPHONES

### OFFICE OF FRANCOPHONE AFFAIRS

**The Chair (Mr. Michael Prue):** Bonjour. We'll wait for the clerk to be seated here.

We will proceed with consideration of the estimates of the Office of Francophone Affairs, which was selected for a total of 7.5 hours of review.

The office is required to monitor the proceedings for any questions or issues that the office undertakes to address. I trust that the deputy minister has made arrangements to have the hearings closely monitored with

respect to questions raised so that the office can respond accordingly. If you wish, you may, at the end of your appearance, verify the questions and the issues being tracked by the research officers.

I now call vote 1301.

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

Madame la Ministre, vous avez maintenant huit minutes.

**L'hon. Madeleine Meilleur:** Huit minutes?

**Le Président (M. Michael Prue):** Oui, huit minutes.

**L'hon. Madeleine Meilleur:** Très bien.

**Le Président (M. Michael Prue):** Et demain matin, 22 minutes.

**L'hon. Madeleine Meilleur:** Okay. Merci beaucoup.

Monsieur le Président, chers collègues, je tiens d'abord à vous remercier tous pour votre intérêt envers les affaires francophones. I know that it's not easy to travel in the middle of the summer, and your presence here today clearly reflects your ongoing commitment.

Le travail du comité est important, non seulement pour informer l'Assemblée législative sur les affaires francophones, mais aussi pour rassurer les citoyens de l'Ontario quant à la bonne gestion financière de leur gouvernement. I therefore appreciate your participation in this committee.

À ma connaissance, c'est la première fois depuis 2003 que le comité sur les crédits budgétaires se penche sur le budget de ce petit « ministère », si on peut l'appeler, que l'on nomme l'Office des affaires francophones.

Cette attention que vous portez envers l'Office des affaires francophones est salutaire, car elle me permet de mettre en relief ce que l'Office a accompli avec moi et les membres de mon équipe au cours de mes trois mandats comme ministre déléguée aux Affaires francophones et ce, avec un financement relativement restreint.

I am confident that my presentation will confirm that the Ontario government can achieve great things and contribute to the development of Ontario's francophone community while relying on a very small budget.

Pour bien mettre l'Office des affaires francophones en contexte, permettez-moi d'abord de faire un clin d'oeil à nos prédécesseurs libéraux, conservateurs et néo-démocrates, qui ont adopté la Loi sur les services en français à l'unanimité en 1986.

Vous le savez comme moi, l'unanimité est chose rare à l'Assemblée législative de l'Ontario. L'unanimité est surtout gage de leadership, de vision commune et de confiance, et d'espoir en une communauté bien enracinée ici depuis plus de 400 ans, la communauté francophone de l'Ontario.

Today, as a result of this type of synergy, I can pay tribute to the vision of Ontario's three main political parties as well as their courage and determination. All together, we ensure that Ontario is a society open to the

world, a society that embraces tolerance through cultural diversity and one where a dynamic francophone community forms an integral part of social, economic, political and cultural development.

Chers collègues, l'exercice d'examen des crédits budgétaires requiert de la rigueur, et je sais que le comité prend ce travail très au sérieux. Mais cet exercice requiert plus qu'une rigueur comptable. Selon moi, il doit également s'effectuer en considérant l'importance globale et le développement durable de la communauté francophone de l'Ontario.

Avec un budget annuel restreint, l'Office y contribue de façon significative en adoptant une approche systémique visant à maximiser l'impact de ses actions dans le cadre de son rôle central au sein du gouvernement. En d'autres mots, nous examinons aujourd'hui ensemble les dépenses de l'Office des affaires francophones dans le contexte du renouvellement des services gouvernementaux entamé depuis 2003, conformément aux besoins des citoyens francophones et francophiles de l'Ontario et conformément à la mission de l'Office des affaires francophones de mettre l'accent sur l'avenir des francophones de la province.

Eight years ago, the government wanted to reinvigorate the French community in Ontario. Despite the very limited financial resources available, we all proceeded to enthusiastically promote Ontario's French community in order to recognize its rich heritage, as well as its ongoing contribution to the prosperity of the province.

C'est là qu'on retrouve la genèse du nouveau budget de l'Office qui, au cours des dernières années, a progressivement et, en fait, très légèrement augmenté pour s'établir à un peu plus de 5,1 millions de dollars en 2012-2013.

Et dès le départ, ce nouvel élan et cette nouvelle ère pour les francophones ont reposé sur une vision cohérente et stratégique dont les objectifs étaient, et continuent d'être, transformateurs et structurants. Autrement dit, nous suivons un plan intégré visant à transformer les services en français, à bonifier les programmes offerts aux francophones et à doter la francophonie ontarienne des outils favorisant sa prise en charge individuelle et collective.

The Office of Francophone Affairs works with the ministries on an ongoing basis in order to help them ensure and improve the delivery of French-language services. For this reason, it is important to make a distinction between the budgets of ministries responsible for the delivery of French-language services and the budget of the Office of Francophone Affairs.

Près de la moitié du budget annuel de l'Office des affaires francophones de 5,1 millions de dollars pour l'exercice financier 2012-2013 est en fait consacrée aux salaires et bénéfices des employés. Ce budget comprend aussi celui du Commissariat aux services en français, de l'ordre de 869 000 \$ en 2012-2013, et celui de l'entente Canada-Ontario de 1,4 million de dollars redistribués aux ministères, ce qui met en évidence le peu de ressources financières dont dispose l'Office des affaires franco-

phones pour élaborer ses propres programmes et initiatives. De plus, près de 400 000 \$ sont dépensés chaque année pour les frais fixes, qui comprennent, entre autres, le loyer et l'équipement informatique.

Today, the team of the Office of Francophone Affairs is comprised of 20 employees: one assistant deputy minister; two directors, each responsible for policies and communication; four administrative employees; three employees in the communications branch; and 10 employees in the policy branch.

For its part, the team at the Office of the French Language Services Commissioner, whose budget is included in the budget of the Office of Francophone Affairs, is comprised of six individuals, including the commissioner. I am sure you will agree with me when I say that this is a small team that accomplishes a lot.

Il s'agit toutefois d'une équipe efficace, un groupe dévoué et un petit ministère fier d'oeuvrer à la jonction même de l'axe de collaboration entre le gouvernement de l'Ontario, la société civile francophone et le milieu d'affaires francophones dans notre province.

I would like to take this opportunity to add that the modus operandi of the Office of Francophone Affairs could serve as a model at a time when the government is facing major budget deficits and is looking for ways to maximize the use of its resources.

Grâce à l'Office, nous appliquons la lettre et l'esprit de la Loi sur les services en français afin de continuer à outiller les employés du gouvernement de l'Ontario afin de les amener à offrir activement les services en français dans 25 régions désignées, selon les termes de la Loi.

Je suis très heureuse de vous rappeler aujourd'hui qu'il existe maintenant 25 régions désignées pour les services en français, dont les désignations plus récentes de Brampton et Kingston, et que d'autres désignations sont présentement à l'étude. Au cours des dernières années, l'Office a également été maître d'oeuvre de la désignation de 225 agences gouvernementales et organismes de l'Ontario. Ces agences et organismes, qui sont maintenant assujettis à la Loi, ont volontairement confirmé leur engagement envers la communauté francophone et l'offre de services en français, et ce nombre continue d'augmenter.

Dear colleagues, the consensus of the three political parties in 1986 has therefore served as the launch pad for the designation of all these regions and all these agencies. I am sure you will agree with me that the clear results obtained in 2012 have validated the vision that our three political parties developed over 25 years ago.

Et, vous le savez, le processus de désignation géré par l'Office des affaires francophones est rigoureux, respecté et surtout structurant. L'Office se soucie toujours de la capacité des ministères à offrir les services en français. Son approche ne consiste pas à faire la police, mais plutôt à nourrir la collaboration et servir d'appui continu.

In keeping with this approach, the Office of Francophone Affairs worked very closely with ministries and agencies to develop and ensure the adoption of a directive on French-language communications, which

would ensure that the specific needs of francophones are considered in the context of all communications strategies during the strategic planning process which precedes the implementation of any communication campaign.

**The Chair (Mr. Michael Prue):** Madam Minister, are you nearly finished or is it going to be more than—

**Hon. Madeleine Meilleur:** No, I am not. Is it the end?

**The Chair (Mr. Michael Prue):** It now being 5 o'clock, I'm afraid we must adjourn for the day. We look forward to your reappearance tomorrow.

Any other business before we adjourn for the day?

**M<sup>me</sup> France Gélinas:** What time tomorrow?

**The Chair (Mr. Michael Prue):** It's 8 till 5, with a half-hour for lunch.

**Mr. Michael Harris:** We won't be here till 5?

**The Chair (Mr. Michael Prue):** Yes, I think we will.

We stand adjourned until tomorrow morning at 8 o'clock.

*The committee adjourned at 1701.*

## CONTENTS

Monday 23 July 2012

|   |       |
|---|-------|
| Ministry of Health and Long-Term Care.....                            | E-293 |
| Hon. Deborah Matthews   |       |
| Mr. Saād Rafi   |       |
| Dr. Arlene King   |       |
| Ms. Patricia Li   |       |
| Office des affaires francophones / Office of Francophone Affairs..... | E-359 |
| L'hon. Madeleine Meilleur   |       |

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