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Ministry of Health and Long-Term Care

Chair: Ernie Hardeman
Clerk: William Short

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Hansard Reporting and Interpretation Services
Room 500, West Wing, Legislative Building
111 Wellesley Street West, Queen's Park
Toronto ON M7A 1A2
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Service du Journal des débats et d'interprétation
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Téléphone, 416-325-7400; télécopieur, 416-325-7430
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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON PUBLIC ACCOUNTS

Wednesday 3 December 2014

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DES COMPTES PUBLICS

Mercredi 3 décembre 2014

The committee met at 1233 in room 151, following a closed session.

2013 ANNUAL REPORT, AUDITOR GENERAL

Consideration of section 3.02, health human resources.

MINISTRY OF HEALTH AND LONG-TERM CARE

The Chair (Mr. Ernie Hardeman): I call the committee to order. Again, we're meeting to discuss section 3.02, health human resources. It's item 3.02 of the 2013 annual report. We have with us the Ministry of Health and Long-Term Care and HealthForceOntario. We have them at the head of the room here.

With that, we will start with your presentation. You will have 20 minutes collectively to make your presentation. Then we'll have 20 minutes for each party in rotation until we've consumed all the time this afternoon. I do ask if you would make sure to introduce yourselves as you start to speak for Hansard so we can get the names properly into the record. Normally, I would introduce you by name, but that still doesn't get it properly into the record because sometimes I have trouble with pronunciation. With that, we will leave it to you to do that.

Thank you, again, very much for coming in. The floor is yours.

Dr. Bob Bell: Thank you, Mr. Chair. My name is Dr. Bob Bell. I'm the Deputy Minister of Health and Long-Term Care. I'd like to start by thanking you for the opportunity to address the Standing Committee on Public Accounts with respect to the Auditor General of Ontario's report on health human resources.

With me is Ms. Suzanne McGurn, who has been assistant deputy minister of the health human resources strategy division since 2011. I should note that in October, Suzanne was appointed the executive officer of the Ontario public drug program. I'd like to take this opportunity to publicly thank Suzanne for her leadership of the health human resources portfolio over the past years.

I'd also like to thank Ms. Roz Smith, the executive director of the HealthForceOntario Marketing and Recruitment Agency, which is the operational arm of the government's health human resources strategy, HealthForceOntario. I might say what a pleasure it is to work with both Roz and Suzanne and to see the terrific collaboration that exists between the portfolio in the ministry and in HealthForceOntario—terrific collaboration and wonderful implementation of strategy and marketing by HealthForceOntario over the years.

Finally, I'd like to thank the Auditor General of Ontario, Bonnie Lysyk, for her report and appreciate her advice to strengthen health human resource planning in Ontario. Thank you.

The Auditor General's report laid out four key recommendations, with an emphasis on evidence-informed physician and nurse recruitment and workforce planning. I am pleased to say that, since this report was released in December 2013, significant progress has been made to address each of the four recommendations. These recommendations were informative and useful as we continued to plan and evaluate our ability to meet patient care needs over time, in an environment where we recognized that health services, health technology and especially the engagement and understanding of our patients and citizens evolves rapidly with time.

Before discussing progress, however, I'd like to provide the committee with context on the health human resources environment prior to the establishment of HealthForceOntario. Prior to the launch of HealthForceOntario, the province experienced a critical shortage of health care providers. Access to primary and specialty medical care was compromised by a lack of health human resources, and services, especially in our hospitals, also in our communities, were hampered by difficulty in recruiting sufficient numbers of nurses to provide care that patients needed.

To give you a sense of the degree of crisis that we were facing, in 1998, 77 communities in the province were designated as underserviced, mainly in northern Ontario. By 2003, the number of underserviced regions had grown to 129 communities, an increase of 68%. By 2006, the number rose again to 137 communities, an increase of 78%.

As you may recognize, the marketplace for health human resources is international and highly competitive. At the time that the health system in Ontario was facing this crisis of availability for health human resources, we were also hampered by the fact that we had no single organization, no point of primary responsibility, to

provide leadership in attempting to recruit and retain health care professionals to address this crisis.

Our efforts at the time were fragmented, conflicting and expensive. Quite often, we experience whipsawing, where one community would be competing with an adjacent community to recruit health care professionals by outbidding adjacent communities for those professionals. This led to competition between communities and between regions of the province for scarce health human resources.

In addition, health care professionals found that education, licensing, registration and regulation systems were complex, especially for health care professionals educated outside Ontario who didn't know our system. We found that immigrants had difficulty getting information, making decisions about career opportunities in the province and certainly great difficulty in understanding the red tape behind licensing, education opportunities and how our system is regulated and how they would become registered.

Employment assistance for recruitment of international providers, or even providers from across the country, was uncoordinated, resulting in losses of productivity, losses of potential years of service, and even sometimes emigration due to significant frustration with the registration system.

1240

Without a sufficient supply and appropriate distribution of providers, Ontario's valued health care system was perceived to be at risk and, also, to put our province generally at risk because of the economic competitive advantage that we enjoy from our publicly funded health system potentially being lost by inadequate numbers of people to provide care.

Following a first ministers' commitment on September 16, 2004, our ministry and the Ministry of Training, Colleges and Universities jointly developed a health human resource strategy. Recognizing that health human resources were threatening the province's ability to provide quality care, Ontario launched the HealthForceOntario strategy in May 2006. This was the first in Canada. Ontario's multi-year, comprehensive health human resource strategy provided an innovative approach to responding to the shortage of professionals, as well as acting to ensure that gaps would not become more extreme.

Working with educational institutions, employers, regulators and health care providers, Ontario focused on ensuring that we had the appropriate mix and number of providers, with the first priority being numbers working in communities across the province to meet Ontario's health care needs now, and planning for the future.

To further support the objectives of the strategy, the government identified the need for a coordinated marketing and recruitment centre. Accordingly, the HealthForceOntario Marketing and Recruitment Agency was established in 2007 as the outward-facing operational arm of HealthForceOntario.

The focus of the agency was to establish a one-stop shop to market Ontario as an employer of choice in health care; to coordinate outreach and recruitment efforts for Ontario, particularly in northern, rural and remote communities; to launch a national and international marketing campaign branding Ontario as the place to work; providing a province-wide listing of job opportunities and a matching service between health care providers and communities that had need; and coordinating efforts to increase access and to explain our system to internationally trained health care professionals.

As the audit report highlights, the strategy has led to significant improvements in the health human resource capacity for the province. Shortages of health care providers generally, including physicians and nurses, are no longer the primary barrier to appropriate access or the cause of wait times. The strategy has mitigated the critical shortages anticipated earlier in the last decade and has improved the province's ability to plan, train and support the health care workforce, now and in the future.

Highlights of the impact's success and the measurable results of the government's investment in the HealthForceOntario strategy include:

—more than 50,000 new regulated providers, including a 22% increase in physician supply and a 13% increase in nursing supply from 2005 to 2013;

—dramatically expanded first-year undergraduate enrolment in medical schools. I need to emphasize the collaboration between Ms. McGurn and the deans of the medical schools in planning and expanding enrolment. Enrolment today in first-year classes is up by 22%, and first-year post-graduate trainees, doctors who have finished medical school and are now getting practical experience in our clinics and hospitals, are up by 64% from 2005 to 2013;

—17,198 more nurses working full-time in Ontario, a 26% improvement from 2005 to 2013;

—different models of care being implemented and developed, including 25 nurse-practitioner-led clinics providing care to 50,000 patients, creating more than 120 new nursing positions providing primary care to patients directly;

—more than 17,600 employment opportunities for new graduate nurses;

—introducing innovative health care provider roles, including physicians' assistants, clinical specialist radiation therapists, advanced clinical practitioners in arthritis care, and five new different types of nursing roles;

—creation of the health professionals database and other evidence-based tools to allow understanding of where our needs continue to exist, and also to inform planning of the health force of the future;

—legislative and regulatory changes increasing the quality and safety of patient care, expanding scopes of practice for individual practitioners and regulating new health professions; and

—establishment of the HealthForceOntario Marketing and Recruitment Agency, which helps communities to recruit and retain physicians and provide support to internationally educated health professionals.

So I think you'd agree that today Ontario is a place where critical physician and nursing shortages are in general limited, and health human resources are an enabler for health system transformation. In this context, work is under way to review HealthForceOntario initiatives to ensure alignment to ministry priorities and health system needs.

Broadly, our work going forward will build on the success of previous accomplishments in reducing acute shortages of health professionals across the system; enhancing all initiatives to support the goals of Ontario's action plan for health care; providing the right care for the right person in the right place at the right time, unlimited by the availability of health professionals; leveraging program evaluation to ensure value for money; and focusing on further enabling workforce transformation and evidence-informed planning of our health system in the future.

Addressing the shifting and evolving needs of the people of Ontario will not be an overnight fix. However, aligning the supply of health care professionals to patient needs is an ongoing recognized priority for us. I'm confident that the work initiated prior to and as a result of this audit report will build on the capacity built through the strategy, to ensure that Ontarians have access to the right numbers and the right mix of qualified providers, now and in the future.

A bit more detail on the work accomplished to address the audit recommendations. Broadly, the ministry has:

—improved physician planning, including the launch of a strategic, evidence-informed approach to medical education planning and meeting with a wide range of physician stakeholders to explore the development of a coordinated approach to addressing current and future physician planning challenges in Ontario, especially recognizing that medicine today requires a constant learning approach—that training and education do not cease at the time that one leaves university or residency, but continues for their entire professional career;

—initiated a review of physicians' initiatives to ensure that they continue to meet the needs of communities with recruitment challenges;

—improved systems and processes to monitor nursing program outcomes, which will support evidence-based nurse planning decision-making; and

—developed a plan to promote the Nursing Graduate Guarantee program, with a focus on the home and community sector, the previous emphasis being in the acute hospital sector. The ministry will continue to implement this plan to improve ongoing participation in the Nursing Graduate Guarantee program.

We want to meet our objective of enrolling more than 40,000 patients in nurse-practitioner-led clinics, we've launched a system to improve the financial oversight of organizations funded to support health human resources, and we've updated information in our existing supply-based models to improve physician and nurse planning, including trying to understand the extraordinarily complex demands of future models of yet-unrecognized care that will evolve during our nursing and physician careers. In addition, we plan to proceed to explore what updates and improvements will enhance population-based funding with population-based risk adjustment for health professional needs in the future.

The ministry looks forward to continuing this important work, and is committed to addressing the recommendations of the Auditor General. Once again, the ministry, the agency and this government would like to thank the Auditor General and her team for the clarity of this audit. These recommendations will become an integral part of our evolving strategy in the coming months and years.

Thank you for the opportunity for this presentation.

1250

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. As I said earlier, we will now have questions and comments in rotation. We start with the government side. Mr. Fraser.

Mr. John Fraser: Thank you, Dr. Bell, Ms. McGurn and Ms. Smith, for being here today and for your presentation. It's very much appreciated. As we had some discussion about it this morning in committee, the thing that we're dealing with here is quite a complex web that you have to dissect.

But I want to talk to you about a few of the recommendations or questions that are raised in the report, specifically with regard to vacancies in northern Ontario. The report states that there are 200 vacancies in northern Ontario, but I've heard there is some discrepancy in those numbers. I hear 61 and the report identified 200, so can someone explain this to me and to the committee?

Dr. Bob Bell: I'll ask Ms. McGurn to answer that.

Ms. Suzanne McGurn: In the report, the 200 vacancies were from a document that was utilized in briefing, actually, the HFO MRA board, which is one piece of information that came out of a consultant report at a point in time. Additionally, as a division, we do evidence-based planning, and so, using other of our tools, our supply-based modelling tools, we've also, over the period of the last few years, done modelling in northern Ontario which had numbers that were closer to 75 and 85 in two different years. I think Roz would probably be able to tell you what's currently being sought from their vantage point.

Mr. John Fraser: That would be great.

Ms. Roz Smith: Thanks, Suzanne. Roz Smith from HealthForceOntario Marketing and Recruitment Agency.

As Dr. Bell mentioned, we have at the agency a job portal called HFO jobs, and at any given moment, we're able to search that job portal and identify the number of opportunities that have been posted on the portal. As of the end of October, there were 61 specialist physician vacancies for northern Ontario on that portal. So that's where the number 61 was identified, and HFO jobs is just

one of many sources where physician postings can be listed.

Mr. John Fraser: Okay. My second question goes to numbers too. Inside the auditor's report, it identifies that we have a decline in participation rate with the nursing graduate job guarantee program. My understanding is, we're graduating more nurses but there's less uptake. It was explained to me this morning that it's the graduates who actually enrol in the program—or is it the institution? That's my understanding, the institution. So if you can answer those two questions for me, that would be great.

Dr. Bob Bell: I can certainly answer that from personal experience. As a CEO of a hospital that has 17,000 employees, in 2006-07 we were delighted to have the Nursing Graduate Guarantee opportunity to hire between 700 and 900 new nurses a year, and through the commitment to actually provide them with mentorship without having a specific line of work to do on the units, we were able to introduce them to a complex health care environment. The dramatic impact that had was, first of all, to allow them to have mentorship and, secondly, to markedly reduce the dramatic number of new nurses who would leave hospitals within six months of their recruitment.

This facilitated their entry into practice, recognizing that acute care, the hospital environment in Ontario, is much more intense than it was 20 years ago, and for a new nursing graduate, just like a new physician graduate, it's a very daunting environment to move into fresh out of school. The new grad guarantee allowed us to introduce them into practice for six months, at a time when we had a dramatic need for nurses across the province.

Now, more recently, because of these young nurses being introduced to practice—these were all baccalaureate-trained nurses, so the first generation of nurses who required a four-year university degree. These are young professionals who see the hospital as their career, and needless to say, the demand for nurses has gone down in the acute care sector.

Where nursing demand continues is in the home and community sector. The new grad guarantee is now shifting its focus toward that, where organization of the home and community sector is perhaps not as solid as it is in the hospital sector from the starting point. So it's not surprising to see the numbers going down as hospital vacancies are being filled.

Mr. John Fraser: So you've got 150 or whatever hospitals in Ontario, but if you look at the community-based, it's—I won't say "exponentially," but it's probably five, six, seven, 10 times that amount from an organizational perspective?

Dr. Bob Bell: There are 650 contracts across the province for health service providers providing home and community care, as opposed to 140 hospitals, so it's not as well organized.

But I think the key issue, the reason why admissions to the new grad guarantee are going down, is that vacancies have substantially reduced.

Mr. John Fraser: Thank you very much. Since you've reminded me where you were in 2006 until recently, I was pleased that you brought up the issue that the specialist shortage is not a driver of wait times and that there are other things that are driving that. I know from your experience—maybe we had some discussion about that. I know it from knowing some people who were in the same position that you were in, trying to manage some of those wait times and the things that are—if you could elaborate on that, that would be great.

Dr. Bob Bell: I'm an orthopedic surgeon by background. Orthopedic surgery is perhaps a good example, because in the Auditor General's report there was a reference to forefoot surgery wait times, a reference to cervical spine wait times. I can promise the committee that this does not relate to a shortage of orthopedic surgeons; we probably currently have a surplus of about 50 orthopedic surgeons across the province. The issue relates to having access to elective operating time to do the types of operations that are described as having long wait times.

You may wonder what forefoot surgery is when you read the report. This is not surgery on people who have four feet. This is reconstructive surgery on the foot, which, many times, is a chronic concern and people wait a long time for it. But it's not like being essentially crippled with arthritic pain in the hip or the knee. This is a bunion, quite often, that needs to be fixed and, quite often, folks can wait for it.

What we're in is a situation where we are expanding what are known as quality-based procedures in the funding of hospitals. We're shifting towards a more activity-based system and we're adding procedures year by year. Many of the procedures that we started with, like hip and knee procedures, hip and knee replacements, were considered to be dramatically needed, with wait times that were far too long with people suffering from quite severe disability.

Those times have largely been solved now. If we look across the province, the waiting times for these really more urgent orthopedic procedures—more than 90% of the population gets treatment within the target of 180 days. Forefoot surgery has a longer wait time. There's not as much emphasis on that. It's not because there are not surgeons who will do forefoot surgery; it's because that procedure has not necessarily been emphasized as we introduce quality-based procedures to the funding model for hospitals.

Mr. John Fraser: I want to ask a question. It's not a numbers question; again, it's a question, actually, that I think we've spoken about before. For the benefit of the committee, I have some interest in scope of practice; I'm beginning to learn more about it. I know that what we're talking about this morning, the change in scope of practice and bringing physicians' assistants, RPNs—

Dr. Bob Bell: Yes, APNs, advanced practice nurses.

Mr. John Fraser: Advanced practice nurses. That's going to have an impact on people's service levels, and that's part of the intent of increasing scope of practice.

Can you perhaps give the committee a bit of an overview of that?

1300

Dr. Bob Bell: Maybe I'll start off and Suzanne will fill in. This is part of the complexity of planning our health system human resource strategy for the future. There's a pretty rapid evolution of the way that care is provided in the province.

Many of you know that over three million Ontarians receive care from what are called family health teams, which are primary care organizations that are really designed to provide interprofessional care, where you would have a doctor or perhaps an advanced practice nurse responsible for your primary care, but you may also receive care from a physiotherapist if you have back pain, from a social worker for psychological distress, from a dietitian if you're diagnosed as having diabetes; your primary care may subsequently be provided most frequently by a dietitian checking your adherence to diet.

So these functions that typically in the past were provided by the sole fee-for-service family doctor have now evolved to a different model of care, where the right practitioner with the right scope of practice for the particular concern the patient presents with at the moment is the person caring for the patient. That obviously pretty dramatically changes the need for primary care doctors, in that their services are now being shared with a variety of interprofessional health providers.

So we've got an idea of how this system will evolve. If I may just take an extra second, since you mentioned specialists before as well, with the increasing availability of population-based primary care, specialist care is evolving pretty rapidly. We're introducing new models of specialist care, where the patient doesn't wait to see the specialist and then come back to the primary care doctor or a letter sent from the specialist; rather, we use e-consultation or new models of care for back pain, diabetes and pain management.

We actually work with teleconferencing methods to increase the capacity of primary care doctors and allow consultants to work on a hub-and-spoke model without necessarily seeing patients to provide data and opportunities to primary care doctors.

It's a rapidly evolving model of practice that's more convenient for the consumer to access. It's client-based. We think it's also going to change the way we provide health services and change the demand for health practitioners going forward.

Ms. Suzanne McGurn: Just to go back, I did not introduce myself. I'm Suzanne McGurn. I'm the assistant deputy minister. I do just want to extend a thank you to the auditor's team. We certainly did benefit from a very great working relationship.

I just want to comment that with regard to the specialist example, certainly there was recognition of the need for us to do enhanced planning as we go forward to be able to take into account many more aspects of what we need in the future than just the numbers, but to include our hospitals, other types of providers etc.

To respond to your question, I think there are a few things that I'd like to say on this. First off, I want to say that I wasn't here but I'm very proud of the fact that I'm implementing a strategy that didn't rely on one strategy to solve the problem. In fact, when you look at what has been accomplished in Ontario, it's because of the courageousness of not just taking one route but many.

So we did look at increasing the numbers. It's not just doctors and nurses; we've increased the production of pharmacists, midwives, nurse practitioners, optometrists—a wide range a health professionals that contribute to us having the opportunity to have a different mix in the future.

We've also done many changes with regard to scope of practice, not just to one profession but to many. Examples would be—one that people talk a lot about are changes to nurse practitioners, things that are no longer having to be done on a list, where they can make choices within their scope on lab tests and drugs etc. They've also been given the ability to admit and discharge from hospital, and other things that have changed the way that they interact with the health care system.

Additionally, we've looked at our regulations, and we've looked at our regulations for regulated health professionals from a number of angles. During the time period of the HealthForceOntario strategy in collaboration with our pan-Canadian partners, we've looked at the ability for labour mobility across Canada, which provides a different grounding for people to be able to move into Ontario as the employer of choice. We've also changed the way that equality is outlined. All of the regulators have had to bring forward changes that have been able to respond to that.

Thirdly, we've regulated new health professionals that were not regulated before, bringing them into structures that allow a different type of relationship with the government and with patients, in recognition that patients have many choices beyond just traditional health care system providers.

Lastly, with regard to the number and types of providers, we have introduced, as was referenced, physician assistants, clinical radiation specialists, advanced care practitioners and new nursing roles. What they have done is given us different opportunities to solve problems in different communities in new and innovative ways. Not one model works anywhere.

For PAs, as an example, we are graduating 54 physician assistants a year. We have 100 in our current education system and we have 160 PAs working in the province. To support them transitioning into a job over the last five to six years, we've also been providing employment supports as people become familiar with them.

We're now at a point, with many of the models and providers that we have introduced, of the system needing to determine how they work for them going forward. We've had an opportunity to provide people with a number of options to solve their challenges in unique ways in each of their own communities.

The Chair (Mr. Ernie Hardeman): Further questions? Ms. Malhi?

Ms. Harinder Malhi: I have a question about the establishment of the HealthForceOntario Marketing and Recruitment Agency. Ontario has been able to focus our health human resources on health system transformation. Can you please point to some of these transformational changes that have occurred since the establishment of the HealthForceOntario Marketing and Recruitment Agency?

Ms. Roz Smith: Thank you for the question. Any opportunity to speak to the work that the agency has done since it was established at the end of 2006 is a welcome opportunity.

We've been fortunate to contribute to the transformation of the health system in a number of ways. Probably one of the most visible, and dear to the heart of almost everyone in Ontario, is the fact that we have prevented the closure of emergency departments. Prior to our existence in the fall of 2006, it was not unusual—particularly for a long weekend in the summer, but not unusual generally—for emergency departments to close as a result of the absence of a physician. These would be smaller emergency departments, where the absence of one physician would result in there being no physicians available to provide care for patients. Through our locum program, the emergency department coverage locum program in particular, we've been able to prevent the closure of emergency departments, thereby ensuring that everyone in Ontario has access to an emergency department when it's required.

As Dr. Bell mentioned, another significant part of the agency's mandate relates to recruitment and retention of health professionals, and physicians in particular. It's important to have the right professional in the right place at the right time to ensure that everyone in Ontario has access. By having staff throughout the province in each of the 14 LHINs, we've been able to assist communities with recruitment of physicians, and through some of the programs that we administer on behalf of the government, we've also been able to assist with the retention of those individuals. We have individuals that speak with community recruiters, share best practices, offer advice on how to actually recruit physicians, match new physicians—that is, newly graduated physicians—with communities in need. That helps to ensure the access and, as well, the sustainability of patient care within the communities.

Another service we offer relates to helping physicians who are interested in moving to Ontario become licence-ready. There are a number of physicians living in the States or living in other provinces and territories who may have gone to medical school in Ontario or may have attended medical school elsewhere, but the bottom line is that they're living outside of the province and they're interested in returning to Ontario or moving to Ontario in order to be able to practise. Part of transforming the system, again, relates to access, it relates to sustainability of care within the communities, and the agency has helped over 1,000 of those physicians return to Ontario and set up to provide practice in communities across the province.

So most of what we have done relates to access and relates to the sustainability of care within communities.

Ms. Harinder Malhi: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time.

To the official opposition: Mr. Walker.

Mr. Bill Walker: Thank you for coming. Quite a learning day it is today; I'm trying to keep up with all of this.

I guess what we heard a little bit this morning—and I just want to start with a generality. It seems, in a lot of cases, I'm not hearing—so I'd like you to clarify if that's not the case—that you have actual numbers that you were estimating and what you were hitting in regard to physicians and by type. Can you expand on that? Can you give me any kind of feedback?

1310

Dr. Bob Bell: We certainly do. Right now, in terms of the general number of physicians who we project will be practising in Ontario, based on the number of post-graduate trainees finishing medical school in Ontario or the rest of Canada or being recruited as international medical graduates, we actually expect, based on our best demand numbers, that we're heading toward a bit of a physician surplus. We estimate, perhaps, a 6% surplus in the year 2023.

The history of physician planning in Canada has been marked by pretty dramatic swings of over-supply and over-demand. We're very well aware of that history. Closure of medical school positions in the mid-1990s led to a shortage that was entirely predictable that we're talking about occurring in the last decade. What we're looking at now is a better way of more gradually modulating the overall number of physicians entering practice and, crucially, also looking at critical subspecialists and specialists.

For example, as I mentioned earlier, we recognize an over-supply of orthopedic surgeons in the province currently. We recognize an under-supply of psychiatrists. Suzanne and I meet on a regular basis with the council of faculties of medicine, comprised of the deans of all the faculties, and this is a very important topic of conversation: how many new entrants into medical school to provide the overall number of doctors, recognizing that that's an "eight year before completion of product" estimation, and also recognizing the distribution of roles that we call post-graduate medical roles—how many psychiatry residents we need, how many pathology residents. This is something that we monitor pretty closely and try to plan appropriately.

We also try to anticipate changes in models of practice and changes in technology. We used to have long wait times for cataracts because cataract surgery took an hour and 20 minutes to complete. Now it's possible to do two to three cataract surgeries in an hour. So, going forward, we probably won't need as many ophthalmologists doing cataract surgery.

So evaluation of the so-called pipeline from its initiation to its subspecialty steps into a variety of different planning regimes for different specialists—combined with an anticipation of where technology and practice is going in the future, it's impossible to hit this dead-on, but we're certainly making every effort to try and do that prediction and build the appropriate supply chains for human resources.

Mr. Bill Walker: In the audit, it shares that you had not met its goal of having the right number, mix and distribution of physicians in place across the province to meet the population's future health care needs. Can you tell me what the right number is?

Dr. Bob Bell: The right number varies from region to region.

Mr. Bill Walker: Are you able to provide those stats, region by region?

Dr. Bob Bell: We could take a stab at it. It would be complex. It would be LHIN-based, it would be sub-LHIN-based. It would be based on how many specialists are needed for small populations. You can anticipate, in a community like Smooth Rock Falls, for example, the distribution of physicians to be different than it is in downtown Toronto, but that kind of planning is undertaken.

Probably the most important thing that we have today in terms of shortages relates to maldistribution of physician resources, especially in northern and rural regions. We're currently looking at a way of enticing physicians, in particular, to consider careers in different areas.

Probably the most important step forward that we've made that's really decreased the maldistribution is the introduction of a new medical school, the Northern Ontario School of Medicine, recognizing that the best way to recruit folks to northern and rural environments is to find physician trainees who are from those regions and to train them so that they're comfortable practising in smaller communities that are, geographically, widely dispersed.

We're trying a number of different approaches, both ways of inducing recruitment to areas that are currently underserviced in the rural areas of the province, and also, crucially, training people so that they have the skills appropriate for working in those areas.

Mr. Bill Walker: I want to go back a little bit. You've been in existence since 2007, as has your association, Roz's association, HealthForceOntario. The ministry's obviously been around a lot longer than that. I'm not trying to be smug, but you're saying that you could take a stab at it, getting numbers. So my concern would be, how would you have expected your strategy to be efficient and successful if you're going to take a stab at it today, six years later?

Ms. Suzanne McGurn: Perhaps I'll take a starting response. I'm going to take a step back. You started asking how do we determine, and what tools do we have. The first thing I want to say, building on Dr. Bell's comments, is that the system continues to change, and what we would plan today could look different tomorrow with a new drug or a new technology. But committed to in the HealthForceOntario strategy from the beginning was to build an improved evidence base for making those decisions. Certainly the audit team has heard me say before that there is no single tool that is a crystal ball that will tell you what you need one year from now, three years from now, five years from now. But we do have tools that we didn't have before, and they do help us contribute to being able to plan differently and, to your point, year over year, be able to look at where our priorities are. So with your indulgence, I'll tell you about a few of our tools and how we use them.

We do have a health provider database—which is unique now in, probably, Canada—which is our health regulators who collect information about their membership. If any of you are a health professional, you know that your application got a lot longer a few years ago. We collect about 50 pieces of information, and that includes a lot about your employment: Are you in a full-time job? A part-time job? Are you seeking other employment? For all of the regulated health professionals, we annually update a database of all of that information, which allows us to know more than just doctors and nurses.

We also have a number of tools specific to physicians. We have an ADIN model that assesses doctors' inventory flow: who's coming through medical school; what's been the history of selection by students; where do people tend to practise; changes in sub-specialization—those kinds of things. Additionally, working in collaboration with the OMA early in the strategy as well, we have an Ontario population needs-based physician model, which allows us to look at, if the world continues in the way we think it is in a particular disease state, what would the need for physicians in a particular specialty be?

So those are, as a grouping, some of the tools we have at our disposal.

Using the needs-based model as an example, if, for example, there was a productivity shift that we saw by something that was emerging somewhere else in the world, or a new technology, we actually could put that in and see what that would look like. If the productivity of our family physicians, for example, was increased by 50%, what kinds of adjustments would we need to make in our model? What we do then is—it's not across Ontario at a given point in time; many things change. Where is population growth? Where is population decline? In a particular community, if you look at it as a single profession—just physicians—it may look like we have an undersupply. But when we superimpose on that whether we have a nurse-practitioner-led clinic or access to pharmacists who are able to do immunizations—when we put the whole package together, as well as information that the agency has, community by community, we're able to better say where it is that we have challenges now.

I would just add to it that the type of challenge differs year over year. When I arrived in the job in 2011, we were still recruiting for critical shortages in some areas. Now I would say what Roz and I spend more of our time

talking about is succession planning in communities, which is, as you're looking at the retirement of physicians or some other profession that has been critical in a small community, it's about matching a new graduate with that community.

So, again, is there a piece of paper that maps out every single day? It's not a piece of paper. It's a constellation of evidence-based pieces of work that we're able to put together to better define and better plan not just physicians, but all health professions.

1320

Mr. Bill Walker: I don't think I'm—

Dr. Bob Bell: I apologize; when I said "take a stab at it," I thought you were going to ask me about an individual community. We've got some of that data, the ratios—

Mr. Bill Walker: No, no, and I'm not looking for that day-by-day. What I'm saying is that it seems there's certainly a disconnect in the number of graduates we're pumping out, with no thought process as to where we need them. We're pumping a lot of people out; I keep seeing in the data that they cannot find full-time jobs. Why are we doing that? Why are putting more people through? Is there a disconnect between the university education system and the health care system so that we're actually putting a whole bunch of students through here who are never going to get a job, and there are huge shortages here, here, here and here? I find it strange. I've tried to read this very quickly, just as we've been talking, to get my head around, a little bit more, the aspect.

You've known for a long time that northern Ontario—what specific things are you doing? If you don't have a number you're trying to address, whether it be for two years or five years—we know there's an issue there. It's a changing number; you still have to have a ballpark. What I read in the auditor's report are words like "the right number," but then you're telling me, "But I don't have a right number because it keeps moving."

Dr. Bob Bell: I apologize; I misspoke myself. We do have a number. We know how many physicians are present. We know the number of vacancies, the number of additional doctors that we need for most communities across the province, if not all.

The other thing that we've got—you commented on the issue of too many doctors in some areas and where we've got deficiencies in others. One of the things we recognized is that it's not sufficient to simply plan the number of physicians coming into the system based on the anticipated need. It's also very important to alter physician behaviour in terms of what they anticipate in their work life.

I'll give you an example: In 2010, Ontario was spending about $15 million a year sending patients with critical neurosurgical emergencies out of province to Buffalo and Rochester because our neurosurgeons were unable or unwilling to accept the care of emergency patients. We couldn't find doctors or hospitals to treat them, and they were necessarily being sent out of country, at great expense.

More than 150 patients left the province in 2011. The number today is zero leaving the province. The reason for that is that we started paying attention, not only to the number of neurosurgeons, but also to the way they enter practice, their age, whether or not they were taking full call, and their accountability to look after sick patients in the middle of the night if they were going to be appointed to our hospitals. What we found at that time was there was a large number of neurosurgeons looking for employment opportunities and senior neurosurgeons who had stopped taking calls. So the number of neurosurgeons actually accepting patients out of office hours, so to speak, was being decreased.

Through Provincial Neurosurgery Ontario, a group that I was fortunate to chair and to develop this strategy with, we started a succession plan where we'd actually help to fund neurosurgeons entering practice with an extra resource being provided to the hospital for extra operating time, with the anticipation that they'd be mentored, starting practice, in the same way that our Nursing Graduate Guarantee worked. New neurosurgeons who weren't used to the high-stress environment of independent practice would be mentored by senior neurosurgeons who would agree that within two years they'd give up their operating privileges, usually entering their late 60s, to their new junior colleague whom they had mentored into practice.

This is almost the evolution of the HealthForceOntario approach. We're past the point of simply planning numbers; we're actually now at the point of looking at physician behaviour around work life, and anticipating how we can have the right practitioners ready to accept the right kind of conditions for work life across the province, appropriately planned in numbers as well as their work style.

Mr. Bill Walker: Thank you. About 33% of specialists who are trained in Ontario at a cost of about $780,000 each do not stay and practise in Ontario. Is there anything in the system currently that requires them to complete any time of practice here, and if they don't complete that, is there any recourse to reclaim that money? If there is, to the first question, I'd like to know the time frame and if that has ever been revisited.

Dr. Bob Bell: Medical practitioners exist in an international environment of recruitment and of transition to positions that are appropriate to their skills, so there is movement. We recruit physician specialists from other provinces across Canada, and some of our excellent trainees from Ontario medical schools and residencies will go to another province to practise their specialty.

In the kind of practices I was in, there were only seven practitioners across the country. With the increasing subspecialization of complex care, we can anticipate movement between provinces occurring. Quite often, we see residents who will come to Ontario for specialty training, and these are amongst the doctors where you described one third leaving the province after completing their training here.

Two things to emphasize: One is that Ontario has one of the best health care systems in the world, and people come here literally from around the world. The hospital that I was at had 150 international surgery trainees coming to practise at the University Health Network for one or two years just to learn the sub-specialty skills and return to the United States, Australia, England with their practice. These would be amongst the people who come here and leave.

The other thing to remember is that while these specialists are here, they're providing vital services. It's not just a question that we're paying them and they learn something and leave; while they're here, they're contributing to the provision of complex care within our system. We're getting good value for these people.

Mr. Bill Walker: This is three quarters of a million dollars, though. So I take concern that the Ontario taxpayer is paying any money—if they're providing service, I can be okay with that. Let's just say it's $200,000 of that three quarters of a million that they're getting paid—then let's deduct that. But why are we paying half a million to them to go to another country? Why are we not focusing on people—and at the very minimum, why are we not building in that there's a minimum requirement of time that they're going to practise after their studies are over so that we get true value? I think this is a true-value audit. Why are we not doing those things and why haven't we been doing those things?

Dr. Bob Bell: When you're referring to three quarters of a million dollars, you're referring to someone who has undergone their total training in Ontario—their undergraduate medical education plus their postgraduate medical education. Those folks would be, in the vast majority of instances, undergraduates from Ontario, and will stay in Ontario. This is where the feature of the Northern Ontario School of Medicine has taught us so many lessons. The best way to get people to practise in northern Ontario is to train them and recruit folks from northern Ontario.

Where you see a greater influence of people coming to the province and leaving the province is in the post-graduate trainees, who are getting specialty training in rare sub-specialties in one area and leaving. For example, I did my postgraduate training in Boston, at the expense of the Massachusetts taxpayer. I learned skills there, I contributed to their health care system and then returned to Ontario. If I had been charged by Massachusetts for coming back to Ontario, I might have been reluctant to return.

There is this inflow and outflow of sub-specialists from the province, and that helps to normalize and optimize the number of sub-specialists that we have here.

Mr. Bill Walker: It suggests that a lot of those people leave because of a lack of full-time employment opportunities despite long wait-lists for the same services, and the auditor notes that the ministry had not collected data from hospitals or analyzed existing data to identify the cause or to develop the solutions. Can you answer that?

Dr. Bob Bell: I can promise you that it's extremely rare that wait times in Ontario are caused by a lack of health human professionals at this point. The long wait times relate to availability of service and the availability of designated operating time or facilities for treatment. As I talked about earlier, there is prioritization of resource allocation. Anybody needing an emergency heart operation in this province will have it within 24 hours. People needing access to treatment for a neurosurgical emergency will receive it immediately. People needing forefoot surgery, their bunion repaired, may wait for some time.

The prioritization of services is the thing that drives wait times in this province today. I won't tell you that our wait times are as good as they should be, and we're certainly working on efficiency within the system and further planning with the system, using funding incentives to try and increase the number of procedures done when wait times get too long in any given area. But it's not the availability of health human resources any longer that drives those long wait times. It was 10 years ago, but no longer—

1330

The Chair (Mr. Ernie Hardeman): If you could just save the rest of it for the next question. Thank you very much for that, but the time is consumed.

Mr. Hatfield.

Mr. Percy Hatfield: Thank you for being here. France Gélinas was going to be here today but couldn't make it, so I'm the designate.

Dr. Bob Bell: Please give her my best.

Mr. Percy Hatfield: I will. She knows so much about this, and I don't.

The last number I heard was that there were 137 underserviced areas in 2006. How many are there now?

Ms. Suzanne McGurn: In fact, the Underserviced Area Program that those numbers are based on was evaluated around the time the strategy was under way, and we don't actually count that way anymore. Roz is probably in a better position to talk to you about the types of communities. I would describe it in a general sense, which was, when we got to the 137 and that program was being looked at, there continued to be pressure from many other areas. So now, in Ontario, our return of service obligation, which is available for a number of types of programs that support medical residents and medical students as they proceed through—they have to make their return of service in a larger area—

Mr. Percy Hatfield: Well, let me interrupt. I just want to keep the conversation going.

I heard that by 2023 we're going to have a 6% physician surplus. The good angel on my right shoulder says "Yay," and the bad angel on my left shoulder says, "Yes, but are they all going to end up in Ottawa, Toronto, Hamilton and London? What about Windsor? What about the north?" How are you going to spread these physicians around in order that everybody gets a fair share?

Dr. Bob Bell: That remains the challenge in our distribution of health human resources. You're absolutely right, Mr. Hatfield.

I won't reiterate the commentary around the Northern Ontario School of Medicine. That has certainly been successful, as has the extension of Western University's medical school, in Windsor—another great example of how areas which are challenged by health human resources can be helped by training folks in their local community.

Suzanne mentioned return of service obligations that we have in place for international medical graduates. I think we need to look at tailoring those a little better. Currently, folks who have return of service obligations are really only restricted from practising in Ottawa and Toronto, and I think we have to look a little more critically at those going forward. That is planned, so that we can look at what areas are appropriate and what areas have the greatest need, in focusing those obligations.

Mr. Percy Hatfield: So when I read that we've spent $3.5 billion over six years on HealthForceOntario, to the general taxpayer looking at the deficiencies in the system now, was that money well-spent?

Dr. Bob Bell: I'll let Roz talk to the issue of how much of that has actually been operational spending to HealthForceOntario. The vast majority of that has been expenditures for salaries and for expansion of medical schools and hospital training programs for residents. It has not actually been for HealthForceOntario.

Roz, do you want to comment on the actual budget of the HealthForceOntario marketing?

Ms. Roz Smith: Our annual budget is in the vicinity of $10 million. We've been in existence since the fall of 2006. So a significant amount of the amount you mentioned is unrelated to the actual agency budget.

Mr. Percy Hatfield: Is there still a need for HealthForceOntario? Or should it be broken down, busted down, replaced with something else?

Dr. Bob Bell: Let me speak to that first, Roz.

Ms. Roz Smith: I have a one-word answer to that.

Dr. Bob Bell: It's probably similar to mine, but I'll probably make it 10 words.

The answer is, it's an evolving role. We're no longer interested in simply bringing as many graduates from other places to Ontario; no longer interested in expanding the medical school enrolment; no longer interested in figuring out how to get a new medical school functioning, getting other residency programs going. What we're interested in now is a perhaps more subtle and perhaps more difficult challenge, and that is, how do we—exactly what you said—ensure that every community across Ontario has access to the health human resources that it needs?

That continues to be a role with HealthForceOntario's capacity for data collection, for recognition of what the local resources are, for anticipation of what services should be in that community and with its understanding of the various inducements that can be provided to get folks to go to practise in those areas.

So I'd say yes, the role is evolving, but the role is still necessary or we'll always be faced with maldistribution.

Ms. Roz Smith: If I could just add to that, I think the question is important from the perspective of ongoing evaluation of what it is we do and the impact we're having. Even though we have a relatively short history in terms of our existence, we already have made significant changes at the agency in terms of what we do.

Dr. Bell mentioned that the initial reason for establishing the agency related to the recruitment of physicians primarily from outside of the province, and there was extensive activity and resources allocated to that. As we moved over the past eight years to stabilizing the supply within Ontario, our focus on recruitment from outside of Ontario has decreased significantly. So we're no longer in other countries to the extent that we were or in other provinces and/or territories to the extent that we were.

Another very significant change that we've made in response to the change in the environment is to expand our reach with internationally educated health professionals into other professions, such as nursing, physiotherapy, medical lab technologists etc., whereas previously we focused primarily on international medical graduates who were already living here in Ontario and interested in becoming licensed to practise in Ontario.

So to the extent that we are able to respond to changes in the system, evolve and identify how we need to change our operations to be more responsive to the needs of Ontario, we absolutely do that and we continue to.

Mr. Percy Hatfield: I know Windsor is deep in the process of trying to justify a new hospital and regional hospital merging, moving, relocating, whatever; yet I know when Soo was here earlier today, she suggested that dinosaurs are teaching in nursing school how to nurse in a hospital, but there are no nursing jobs opening up in hospitals; they're all community nursing jobs. When are we going to convince the educators to switch their focus from hospital-based nursing to community-based nurses?

Ms. Suzanne McGurn: Perhaps I'll just respond. Your comment is apropos and it is a conversation that actually is already under way. In my role as assistant deputy minister, I report to both the Deputy Minister of Health and to the Deputy Minister of Training, Colleges and Universities. We have a close working relationship with our colleagues. We also have a table of stakeholders of nurses that includes all of the nurse educators, including the colleges, the universities, as well as a range of nursing stakeholders, the community and the employers, and we have these conversations.

You are increasingly seeing placements outside of hospitals. We have conversations, and changes are being made to recognize that when I went through to be a nurse a hundred years ago, you learned medical complexity patients in an acute care hospital. There's just as good an example and as good an opportunity to learn now in long-term-care homes where there are medically fragile patients. So those conversations are happening.

Curriculum is being adjusted and it is increasingly being attended to.

I would also add that Dr. Bell mentioned in an earlier response that there's a need for lifelong learning. As we have different populations to care for in the future, whether it's mental health or the aging population, we are now finding new ways to collectively educate together. Just this fall, we held a summit—all educators, not just in one profession—on how to learn to provide care and teach differently to make sure we're caring better for the elderly, as an example.

Mr. Percy Hatfield: That's a good point because every week, as members, we get approached by different silos. The scope of practice is evolving. People want more ability, more authority to do different things in health care, so it's an evolving science, if you will.

What can we do to accelerate that so that nurses can do more, pharmacists can do more, nurse practitioners—all of the people who are saying they can do more and, therefore, improve the system, how do we accelerate the breaking down of those silos?

Dr. Bob Bell: What you're talking about is really a cultural change as much as it is a change in the scope of practice of professionals. Ontario is actually the leading jurisdiction in the world. It's been recognized by the World Health Organization for its attention to what we call inter-professional curriculum in our medical schools and residency programs.

1340

It's extraordinary, when you think about it, that we expect doctors, physiotherapists, occupational therapists, nurses and social workers to work together in teams when we train them in separate schools and they never see each other when they're in their training. Ontario has actually led the world in breaking that down. The first-year curriculum now at the University of Toronto medical school, which I know about best, is done in collaboration with the faculty of nursing and other schools. Certainly this concept is starting a culture early on of recognizing and, importantly, respecting the skills and the backgrounds of the various collaborating professions. It's probably a critical step to getting that flattening of silos and integration of care that our clients expect.

Mr. Percy Hatfield: You mentioned, Dr. Bell, that we don't do neurosurgery in Buffalo or Rochester anymore, but we still do cardio in Detroit. Detroit has bailed out many a patient from the Windsor-Essex county area when they've had emergencies. Is that something that you see as continuing, or is that going to come to an end at some point as well?

Dr. Bob Bell: As you know, the investment in angioplasty at the Windsor hospital is welcome and I think it's going to help to modify that.

Mr. Percy Hatfield: Oh, I'm sorry. So you've finished?

Dr. Bob Bell: Yes.

Mr. Percy Hatfield: All right. I know we're working on it. That's a good thing.

You also mentioned, I believe, that we're not doing as much now in doctor recruitment because the process is in place. I know in Windsor-Essex county the city stopped funding their recruitment officer, but the county continued. I imagine that municipalities across the province are still paying, at the municipal tax level, to recruit physicians to their communities. Is there a redundancy? Or should there be better coordination on physician recruitment across the province through your agency?

Dr. Bob Bell: Do you want to answer that?

Ms. Roz Smith: Yes, I would. We don't see that there's a redundancy. We have individuals called regional advisers who exist in each one of the local health integration networks. What they do is work with all of the physician recruiters in their particular geographic area, which crosses multiple municipalities. Some of those municipalities contribute financially to their own community recruiters and many others do not. Some of those community recruiters have responsibility for more than one municipality as well, or more than one geographic area.

What we do is we communicate with all of those within that particular geographic area. We share best practices. We connect new physicians with the opportunities in that particular area, and we do that provincially as well because there's an advantage to not only sharing information within a geographic area, but across the entire province. We don't replicate the services that are provided by community recruiters; we enhance and support what it is they do.

Mr. Percy Hatfield: Has the ministry or HealthForce-Ontario taken a position? Or are you in any way studying LHINs and CCACs to see whether there's an opportunity for savings or money better spent by either merging or some new focus on those two?

Dr. Bob Bell: One of the ministry's main priorities over the next few years is to really focus on a modernization of home and community care. We spent a lot of time working on various innovations in the hospital sector and the acute care sector, but I think we recognize that home and community care has been somewhat dormant from the perspective of innovation. Those 650 contracts that I've mentioned—most of those have been in place for many, many years.

There are all kinds of innovations that have been introduced in home and community care—Telehomecare, for example, a way of monitoring somebody's diabetes care, somebody's blood pressure at home, talking to them over Skype. These are innovations that we started in Ontario, but they haven't scaled up tremendously well. I think it's fair to say that the organization of home and community care requires the expertise present in the CCAC and requires the planning skill necessary in LHINs. I think those functions are absolutely required.

We're expecting the expert panel, chaired by Dr. Gail Donner, to report back in January. This is a panel that has been requested to provide us with advice regarding modernization of home and community care, including structural change, if appropriate. But our anticipation is

that the services currently provided by CCACs—the estimation of the types of services required, the measurement of the degree of disability the patient suffers, what they require in their home and the best way to achieve it—are absolutely going to be required.

Mr. Percy Hatfield: The right mix of medical professionals at the right time in the right place, I guess, is probably one of the biggest challenges. What can we do to make sure that the mix is identified and encouraged in each of our smaller municipalities?

Dr. Bob Bell: That's an excellent question, because that complexity becomes greater as we look at inter-professional care. It's not just a question of the right number of doctors or right number of nurses; it's a question of the right number of various skilled professionals working together in a team-based model.

I'd say that over the last four years, five years, since the introduction of family health teams, with three million Ontarians now coming to be provided with primary care, we've learned a lot. The foundational investments have been made. The Auditor General has told us that perhaps the return on investment for that model needs to be enhanced, and we have plans under way to enhance that investment.

We think the structures are correct, and we think that what we've learned over the last five years with the development of inter-professional care will accelerate in the longer term, and the very thing you are suggesting will become a real focus for us: How do we make sure the right mix is there and provided in a team-based model, so the mix isn't dependent strictly on one professional—the requirements can move back and forth across an inter-professional team as the patient's needs change.

Mr. Percy Hatfield: I don't know the answer to this question: Do most hospitals have surgical rooms 24/7, or are they nine-to-five or 7 o'clock to 3 in the afternoon?

Dr. Bob Bell: The hospital I used to be CEO of had a total of nearly 40 operating rooms, of which there would probably be five or six running 24/7, mainly because it's a transplant and neurosurgical emergency hospital. So five of the 40 would be running 24/7, and the remainder would be running either 8 o'clock to 3:30 or 8 o'clock to 5 o'clock.

Mr. Percy Hatfield: Would it be cost-effective to make more use of the operating rooms, which I would think would reduce wait-times for any number of medical—I don't want to say "emergencies" but medical needs? Would it be cost-effective, or is there too much overtime involved or not enough staff? What would it be?

Dr. Bob Bell: It wouldn't be overtime as much as we'd be paying shift premiums. For example, staff who come in at 3:30 and work till 11:30 would have a small shift premium, not overtime. The issue is simply operating funding. How much funding can we afford for the hospitals? As you know, the cost curve has bent significantly. Hospitals used to have incremental funding of 4% to 6% per year, and that's been bent in the last couple of years where hospital base funding has been held flat at 0% while still allowing hospitals to have activity-based funding that varies by the amount of activity that is undertaken.

This model has served to increase efficiencies at hospitals. What we call cost per weighted case, which is the final criteria for cost-effectiveness within hospitals, has improved with the introduction of new funding methods. It has also allowed us to target specific funding at specific aspects, wait-times being one of them or the introduction of new technologies being another. It has allowed us to target funding based on individual activities provided in hospitals, rather than simply increasing the hospital-based budget by 2% per year or 4% per year without asking what activity is actually being undertaken. To use the term "surgical," what goes on in hospitals today is a much more surgical form of planning.

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the first round. The next round will be 18 minutes per caucus, and we're starting with Mr. Potts.

Mr. Arthur Potts: Thank you, Dr. Bell. I appreciate your comments thus far. If I could maybe pick up quickly on Mr. Hatfield's comment about surpluses in the system, anecdotally, my godfather, Larratt Higgins, was the chief forecaster for Ontario Hydro, and he was in front of a committee very similar to this many years ago, talking about excess capacity in the hydro sector, when we had too much power. He equated it, at the time, to being much like Sir John A. Macdonald's consumption of gin: "Maybe a little too much is just the right amount."

Now, that's my question to you: Do you see us in a position here where it's a benefit to be a little bit over plan? Is it a precautionary benefit, or is it a problem for us going forward?

1350

Dr. Bob Bell: I thought you were going to ask whether our planning improved with our consumption of gin. The answer to that is that it's hard to tell, because physicians are expensive resources. Probably having a 6% surplus is something to avoid. Probably a small degree of surplus is appropriate. That's where this concept of inter-professional teams is so important, because it allows us to have a little more elasticity in our planning functions, in that we're not totally dependent on a single professional to provide care.

The other thing that we're very aware of is that, with current enrolments, if we were to continue at the same rate, our projection wouldn't be a 6% surplus; it would probably be a 10% surplus by 2027. That kind of swing in supply and demand is what we want to avoid.

Mr. Arthur Potts: Fair enough. Thank you.

The Chair (Mr. Ernie Hardeman): Mr. Rinaldi?

Mr. Lou Rinaldi: Thank you, Dr. Bell. First of all, I congratulate you and HealthForceOntario on the work that's done. As I said in my first stint here at Queen's Park, back in 2003, many of the calls I used to get in my constit office said, "There are no doctors around." I can say that, although there are some challenges in the north,

that's not an issue that we face—mostly for GPs; specialists are still a little bit of an issue.

Having said that, though, one of the issues—I have three hospitals in my riding, so that's a bit of a challenge of its own. But when I meet with the hospital chairs and CEOs almost on a monthly basis, there's still the issue about emergency docs. In some cases, they struggle sometime during the month; they put the SOS out. I'm sure you know all about this.

Can you tell me how HealthForceOntario is tackling that issue? That's a real, outstanding issue, I think.

Ms. Roz Smith: Well, thank you. That's an absolutely critical issue and, as I mentioned earlier, one of the higher-profile issues in which the agency is engaged. We've considered that we've made quite a bit of progress in the seven or so years that we've been in existence. There are significantly fewer calls indicating that there is a crisis because a physician is unavailable and an emergency department may close.

The other key aspect is that—last year is an example: We had 25 hospitals that participated in the emergency department locum program. Last year we also had 12 of those hospitals that successfully recruited physicians and were able to no longer have to rely on the program. Previously, in our early years—the first, second and third years of our existence—we had hospitals access the emergency department locum program and stay on the program for an extended period of time because they were not successful in recruitment.

A number of the recruitment initiatives that Dr. Bell and Suzanne have mentioned have led to successful recruitment of emergency physicians, to the point where our locum program really is an interim measure: a physician leaves, they initiate the recruitment process, they end up being successful in recruitment in one, two, three or four months, and then they no longer have to rely on it. There's more of a—I won't say revolving door, but there's more short-term access to our program than there was previously.

Another initiative that we are undertaking a lot more now than we did previously is providing consultative advice to emergency department chiefs, hospital CEOs and chiefs of medical staff within the hospital. With our seven-odd years of experience, we've had the benefit of learning from multiple hospitals what it is they do and what it is they do well, and we're in an ideal position to share that with other organizations.

Last year alone, there were close to 20 hospitals with whom we spoke that wanted to access our program. When we spoke with them, we identified what some of the areas of concern were. We helped them address those to the point where they were no longer requiring a locum physician, because we were able to share some of the practices that we have learned over the years.

Our primary objective continues to be to avoid the closure of any emergency department as a result of the absence of a physician, and we're doing that in ways beyond just providing additional physician resources to that emergency department.

Mr. Lou Rinaldi: Thank you. I think—oh, sorry.

Ms. Suzanne McGurn: I was just going to add: In addition, we do have some targeted education programs that are helping to bridge what was the problem in the past, where some practising family physicians didn't feel that they had the skill or knowledge. We have a number of programs now where we've been able to provide that training to physicians that has allowed physicians that already existed in the community to take on roles in the hospital or, as Roz says, actually be recruited to provide it on a more permanent basis.

Mr. Lou Rinaldi: Thank you.

The Chair (Mr. Ernie Hardeman): Mr. Dong.

Mr. Han Dong: Great. First of all, thank you very much for coming to the committee and giving us an update on some of the progress that your agency has done in response to the AG's recommendation. I was listening to your response to Mr. Hatfield, and in your response you talked about internationally trained health care professionals. Perhaps it's because I'm a first-generation immigrant or perhaps because my downtown riding houses many newcomers who are looking for opportunities in the health care sector—is it possible for you to elaborate? I paid attention to what you said about the effort to recruit internationally being suspended or turned off—sorry; am I wrong?

Ms. Roz Smith: Reduced.

Mr. Han Dong: Sorry; it just kind of declined. Exactly. Your focus has been moved to how to better integrate the existing local immigrant perhaps to other services. Can you elaborate on that and just tell us what else you're doing to help them to integrate in the system here?

Dr. Bob Bell: Maybe I'll just start off by mentioning that we have about 1,000 students a year who go on to training—post-medical school training—as residents who are trained in Ontario's or Canada's medical schools. Last year we took 220 folks who had international medical training into residency training in Ontario's residency programs. So the program is actually as big as it ever was, but the focus—you're quite right—is more on physicians who have arrived here now looking to start a medical practice as opposed to actively recruiting folks to come to the province from outside its borders.

In terms of how that program has evolved, Roz, can I turn it over to you?

Ms. Roz Smith: Yes, absolutely. In the years that we have been in existence, we have had the opportunity to speak to 15,000 internationally educated medical graduates. The communication we have had with them covers a broad range. We have a fairly comprehensive website and we have individuals from across the world who access our website.

We have Skype sessions. We have been doing that for the past few years, and we have individuals, again, in other countries who access those services. We have webinars, and then, of course, we have in-person sessions that are both one-to-one and group. So the 15,000 that I

mentioned encompass all of those various types of interaction.

Mr. Han Dong: How successful is it?

Ms. Roz Smith: We've been very successful. Of those that we've seen, over 2,000 of our clients have been successful in either being licensed to practise as a physician, or have chosen and have been successful to move into an alternative career, whether that's a medical lab technologist or a pharmacist etc.

Mr. Han Dong: How much time do I have, Chair?

The Chair (Mr. Ernie Hardeman): Nine minutes.

Mr. Han Dong: Nine minutes? Okay.

Can I quickly ask another follow-up? We talked quite a bit about the inadequate service in the northern or rural communities. Is there, in your mind, any way that we can encourage these internationally trained health care professionals to look at moving into those communities, because to them, the effort—well, I'm not saying that the effort of adapting to an urban environment is the same as adapting to a rural environment, but they do have to settle. For them, maybe it's more beneficial to settle in an environment where they have very little chance to use their native language. Maybe it's better for them to practise and learn the culture here in Canada.

1400

Dr. Bob Bell: I think that represents the evolution of the challenge that we have and that HealthForceOntario is responding to. Previously, we had communities across the province that had an insufficient supply of doctors, so the return-of-service obligation, which is five years of committed practice in an environment, is in response to being admitted as an internationally trained graduate to the Ontario workforce.

We had a five-year commitment, but that was a very broadly distributed return-of-service obligation. We're thinking now, as communities across much of Ontario become better served, that we can start focusing it now in areas where there's a real shortage.

Some of the challenges, of course, relate to the fact that folks come with cultural challenges, and the smaller communities perhaps represent an even bigger cultural challenge. But it's a wonderful opportunity to be a doctor in this province. We think that a return-of-service obligation can certainly be applied to target folks to the place where they're needed most, so we're looking into that now.

Ms. Suzanne McGurn: We're also looking to support others. The Nursing Graduate Guarantee that folks are aware of through the report has been expanded to support internationally educated nurses as they transition in which, again, will help them settle into a community differently.

We've been working collectively with the agency and with our federal counterparts to do some research on what actually are indicators and strategies that can be used to help internationally educated or new-to-the-country individuals to better move into practice. That's something that the agency is working very closely with us on.

Mr. Han Dong: Great. Thank you.

The Chair (Mr. Ernie Hardeman): Mr. Potts.

Mr. Arthur Potts: Yes, if I can. At the end of your remarks, Dr. Bell, you talked a bit about the population-based models that you're moving forward with. When you do your assessments of population, are you taking into account seasonal variations?

I'm thinking particularly about university towns. I had a group of students through here yesterday who talked to me at length about mental health in universities and physical health issues. Their primary care doctor will be back in the city where they live with their parents for four months of the year, but when they need care during the high-stress period in the university, they're not allowed to access care because their primary practitioner is elsewhere.

As part of this modelling, are we looking at university health, student health?

Dr. Bob Bell: That's a great question. Thanks for that. A couple of weeks ago—10 days ago—the minister announced the mental health advisory council, which is going to help us to drive the mental health strategy, which we recognize is a really big needed element of the health system.

One of the big pieces of that is, this is an interministerial, whole-of-government approach to a mental health strategy. It includes the Ministry of Training, Colleges and Universities, because one of the most common presentations of serious mental health problems, and one of the most common cases where psychotic illness presents, is at what we call the "transitional age," from adolescence to early adulthood.

Oftentimes, the stress of first-year and second-year university or exams at Christmas is the first sign of somebody demonstrating severe depression, or even schizophrenia. You're absolutely right: away from home, in a stressful environment. We need to ensure that our university population has access to appropriate mental health services.

That's certainly better today than it was five years ago, but it needs to be a very significant part of the interministerial approach to the mental health strategy that we're adopting now.

Mr. Arthur Potts: Thank you. I appreciate that.

Ms. Suzanne McGurn: I would just add that one of our nurse-practitioner-led clinics is actually very closely related with an educational facility and does serve that kind of population, so there are emerging models that we will hopefully be able to build on in the future.

Mr. Arthur Potts: How much time have we got?

The Chair (Mr. Ernie Hardeman): You have about two minutes.

Mr. Arthur Potts: Well, maybe expanding on that, then, outside the university sector: tourism issues, as you get into the north and the cottage period of time where people are experimenting with water sports and a whole series of other things.

I know that up where we have a place, in Dorset, the nurse practitioner's station is coming, we hope, soon. To

have a fishing hook taken out of an earlobe and not have to drive to Huntsville for it would be a real benefit in that community. Can you maybe comment on those kinds of seasonal patterns?

Dr. Bob Bell: Yes. There's no question that our colleagues who run advanced practice, nurse-practitioner-like clinics in some of the more rural areas of the province provide a wonderful service. The further away you get from high-density population areas, the more likely it is that primary care will be provided by a nurse rather than by a doctor. This is a very flexible model, as you recognize.

Also, those places that you're describing, with a seasonal population variation—there's a big demand on emergency departments, as well, where nurse practitioners play a role now—a very significant role—in managing lower-acuity, so-called CTAS 4 and 5 patients as they come into emergency departments. Certainly, that's a great example of the expansion of scope of practice for nurse practitioners really serving as a very useful expander to service in areas that have a seasonal variation in population.

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes your time. Ms. Munro.

Mrs. Julia Munro: Thank you very much for coming here today and giving us such good insight into this whole area. I want to take our conversation further on in the work of the Auditor General and looking at particularly the areas around nursing and the initiative of the Nursing Graduate Guarantee program.

Obviously, this goes back to a political decision that 9,000 full-time nurses—but when we look at the information that is provided, it seems that, in fact, when you go from the fiscal year 2007-08 to 2011-12, we actually see quite a dramatic decrease in the number of people who have participated; the lowest is 35% participating. At the same time, obviously it comes with a price tag, so you're looking at the lowest year with, I think, not quite the highest amount of money but close to it.

This is a two-part question. One is, obviously, why isn't this working the way that it was intended? I understand it to have provided for 26 weeks with the idea that at the end of the 26 weeks the individual would blend into a full-time position. So the question around that part of the program, and then the second one on the cost of the program and what that reflects, because it seems to go in the opposite direction than you'd expect.

Dr. Bob Bell: Maybe I'll start off and simply mention that the uptake and then the decline in the number of new graduates enrolling in the new Nursing Graduate Guarantee relates to the success of HealthForceOntario's various initiatives. When this program started, the nursing workforce of Ontario was characterized by a fairly small proportion of nurses who actually had full-time roles and, I would say, an excessive reliance on part-time and casual workers.

The Nursing Graduate Guarantee said, "We will only provide funding for the nurse to have this period of training and orientation if there is a full-time job guarantee." Because of that, the proportion of our nurses who have full-time status in our hospital sector—and I agree with earlier comments that we need to focus this into the community sector now. The number of full-time employees is approaching 70%, which was a target. It's not quite there but it's pretty close. That has decreased the demand for new nurses or the vacancy-driven demand in our hospital sector.

The workforce is much more reliable as a full-time workforce and the volatility of the workforce by nurses changing positions within casual pools has dramatically decreased. I'd say that the decline in the enrolment in this program relates to the success of the program in solving the large problem that we had at the start.

Suzanne, do you want to add to that?

1410

Ms. Suzanne McGurn: I would just add that it's important to understand two aspects of the program, one of which is that there were jobs available at the time, and as other initiatives, such as the expansion of nurses through the 9,000 program etc.—nurses were able to move into permanent full-time or part-time jobs and in some of those cases they did not have a need to participate in the program.

The benefit that the program gave as one of its key considerations is that recruitment within hospitals is often not at the point in time at which nurses graduate, but over a period of time, the successive few months, there would be an opportunity for jobs. The benefit of the Nursing Graduate Guarantee program meant that a graduating nurse who was likely to be hired by an employer on a permanent basis, hopefully full-time but at least permanent part-time, had the opportunity to go to work in an organization such as UHN, as an example, and gain that experience during that up to six months in a full-time way. Prior to that, they would have been waiting at home to be hired without that experience.

Again, just to support the comments from Dr. Bell, the actual matching of it was never intended to be that there would be a job for every person. It was to provide an opportunity that where there were likely to be jobs and there was an intention to have a permanent job, preferably full-time, nurses were able to transition more smoothly and in a supportive environment where they got to learn, rather than being in a casual pool where we were seeing great attrition rates from hospitals because it wasn't a welcoming atmosphere to move into this very complex health care environment. I hope that's helpful.

Mrs. Julia Munro: Now, in responding to the auditor's recommendations and the suggestion about monitoring the employment trends and assessing the reasons for the decline and things like that, would you then sort of tick a box that this has been successful and would you be re-evaluating the need, and obviously the cost and so forth?

Dr. Bob Bell: I think the issue is very successful in terms of solving the problem of dramatic vacancy issues limiting access to care within our hospital sector that were present in 2004, 2005 and 2006, where literally

patients' operations would be cancelled as they waited in the anteroom to surgery because insufficient nurses were available to provide that care. Those kinds of problems just don't happen any longer.

What we do see now is the issue of the flexibility of the workforce, the specialization of the nursing workforce, which is really an important element, and also the relative volatility of a workforce that relies on young people, predominantly women in their child-bearing years, to provide the really major part of the workforce in our hospitals.

So acute planning is a crucial issue. It's mentioned in the Auditor General's report that the hospital that I used to work at was being engaged to provide a short-term forecasting tool where the nurse managers in all the units at that hospital will go around and say, "Anybody planning on leaving in the next six months?" It seems like a straightforward thing, but if you have six months' notice for somebody who's going to deliver their baby, you can afford to actually provide a replacement as opposed to finding out two weeks before they tell you they're going on pregnancy leave. And that actually used to happen. It's hard to believe that in a health care system we wouldn't anticipate pregnancies, but we didn't, believe it or not. And it's not just pregnancies; it's also leaving town for family reasons or retiring for a short term for child care reasons. That kind of a proactive approach, that tool, is now being used across hospitals, and it's been quite useful in terms of short-term planning for nursing vacancies and allowing hospitals to proactively recruit so that an oriented staff member is available when the former staff member goes on leave.

Ms. Suzanne McGurn: I would just add—it was included, I think, in our response— that we actually have launched, or were launching at the end of the auditor's visit to our area, a new actual management model that allows us to collect information: a lot of the questions about what happened and why we didn't have the information. That model's now been in place a year and we are able to start answering those questions, doing analytics and being able to make recommendations to change the program based on what we learn from it.

Mrs. Julia Munro: You've provided me with the perfect segue to my next question. In looking at that kind of modelling, which it is clear to all of us is necessary—it's the computerized version of the crystal ball, I think. The point is, though, that I, as an observer, would comment that there are still a lot of barriers.

We talked earlier about the silos, and we talked about the independence of some of the players. They have separate funding streams, or there are historic funding streams that make no sense whatsoever, in my opinion. There are obviously a number of those kinds of things.

I just wondered if you would comment on the modelling that you are doing, obviously recognizing that these are the kinds of obstacles you have. Is there a best case that you see, where in another jurisdiction or something like that, people seem to have done better?

The final part of my question is, one of the things—and I stand to be corrected because it was years ago—when Cancer Care Ontario was very active, not to say they aren't now, but in the earlier part of their history, they were able to collect information from hospitals and make sure that wait times were reduced by the ability to go to a different hospital. Is that a model that can be made into the care in other medical circumstances?

Dr. Bob Bell: I'll start with your latter example related to the cancer system. As the chair of the Cancer Quality Council in Ontario for four years, I'm proud to help start that system off.

It's extraordinary what can be achieved with a system of performance management, where you collect accurate data related to wait times—not only related to wait times, but also related to the number of lymph nodes being removed with a colorectal cancer, seriously, or what the surgeon's independent personal rate of prostate cancer positive margins is, and you make that information available on publicly accessible websites.

To give probably the best example, the rate of positive margins in prostate cancer surgery, which is a big indicator of whether the cancer is removed completely at the time of surgery, used to vary across this province from about a 13% positive rate, which was an international best practice, to about 50%. After that information became publicly reported, within a year, that variability had dropped dramatically. That kind of performance management at an individual level, as well as the kind of performance management—when I was vice-president of Princess Margaret Hospital, I'd have a meeting with Cancer Care Ontario quarterly where they'd say, "Why are your wait times for ovarian cancer surgery beyond the level 2 limits?" And I'd go back and ask the ovarian cancer surgeons, "Why are those wait times"—

So you're absolutely right. That kind of performance management is something we want to introduce across the health care system so that when we ask, for example, our leaders of LHINs, "What proportion of patients in primary care get access to their primary care providers within 24 to 36 hours if they're ill?" we can expect that our LHIN leaders will have the answer and they'll be able to tell us which primary care practices provide access and which don't.

We'd anticipate in the next few years that information will become available on publicly reported websites, and I think that will be a big inducement to an improvement in primary care. Dr. Hoskins is entirely supportive of that approach, and that's part of the strategy that we anticipate.

Mrs. Julia Munro: I think it's very exciting to hear about that.

Dr. Bob Bell: Thank you.

Interjection.

Mrs. Julia Munro: Oh, five minutes.

Did you have anything else you wanted to add? I have to find my notes.

Mr. Bill Walker: Yes. So a commitment to hire 9,000 nurses—and I think they said there were about 7,500 or

7,300 hired. Can you just tell us why, when there's such a number of nurses apparently unemployed, we haven't hit that?

1420

Ms. Suzanne McGurn: I think there are a couple of things to be aware of. There are two programs, one which is very targeted investments for new types of nurses and new roles in the health care system that were funded under the 9,000 nurses, as well as, there were general health care increases to hospitals, to the community etc. Both of those changes were contributing to the higher employment of nurses. In fact, we have more than exceeded the 9,000-nurse commitment. In our most recent information we have, I believe, 13,000 or 15,000—with apologies, over 20,000 new nursing positions since the initiative started. We've met our 9,000-nurse commitment specifically, as well as we have enhanced nursing positions being created.

Some of the things to be aware of as far as the point in time in which the audit was done: A number of the 9,000 nursing initiatives were just rolling out, so all of the positions had not yet been filled. That does reflect in some of the differences in numbers that you see in the report versus the overall where we are at this point in time. But again, if you use nurse-practitioner-led clinics as an example alone, the establishment of 25 nurse-practitioner-led clinics created over 120 nursing positions, and not just nurse practitioners but other nursing roles as well. We had navigator positions that were able to go into people's homes immediately following discharge from hospital to be able to assist with planning in a more timely fashion that would allow interventions to prevent patients from going back to emergency departments.

There were other nursing initiatives like that that, over the course of time, people had to staff up for, and it was recognized that in some parts of the province, the actual ability to recruit nurses or NPs—they had to wait for a graduating class, and then they used the Nursing Graduate Guarantee, or otherwise, to be able to fill those programs

Mr. Bill Walker: Okay. I'm probably going to run out of time on your behalf to be able to answer this, but I think it should at least be addressed before—we probably won't get to speak again. The auditor's recommendation to improve financial oversight: Can you give me a bit of a snapshot of the ministry's steps that you've taken to improve financial oversight of funded organizations and particularly the recovery of unspent funds?

Dr. Bob Bell: Yes. In-year cash management has become an increasingly important focus for us. Each year, the gross amount of recovery has reduced because we're—sorry. The prior years' recoveries—that is, recoveries from previous years—have reduced because we're doing better in-year cash management. That has been recognized as an important element. Whether it's for the Nursing Graduate Guarantee or whether it's for activity-based funding provided to hospitals based on achieving 150 cases where only 130 were achieved, we're doing a much better job now of recovering that, oftentimes based on Q2 interim analysis. Where hospitals are obviously not going to hit their targets, we'll do recovery in-year. When that's not possible, when we're waiting for the full-year and understanding the expenditures and the activities for that full year, we'll do a recovery early in the subsequent fiscal year. Our performance in that regard is improving.

Mr. Bill Walker: Okay. One last one: I read just further into the report. Certainly, the ability to have enough hospital surgical suites to be able to perform the surgeries that are needed—there are wait-lists in a number of different areas. Yet there seems to be a movement to look particularly at rural and small rural Ontario northern hospitals, and shut them down. In many cases, you have that surgical suite, you have the availability, yet you're going to cut them down, which to me would suggest that you're going to have an even larger backload and wait-list for those types of things.

Dr. Bob Bell: That's an excellent question. Thank you, Mr. Walker. The issue of wait-lists does not currently vary with available human resources, nor does it vary with available operating suites. It varies based on available operating funds to hire people to work in those suites. The staff are available; the surgeons are available; and, generally speaking, the operating rooms are available, as we mentioned to Mr. Hatfield. We're not running our operating rooms much past 3:30 or, at latest, 5 o'clock. So the issue is not the capital stock; I'd say the capital stock is underutilized. The issue is operating funding and targeting our scarce operating dollars toward those wait times that are most crucial for patients. That's the activity-based funding direction that we're taking.

In terms of closing operating rooms in smaller rural hospitals, this is a real issue. You come downtown to see Mamma Mia!; would you not come downtown to get your brain tumour operated on? The issue of quality with today's technology is a real issue. Small and rural hospitals have increasing problems keeping the specialists with sufficient volumes of activity to maintain excellence and competence.

Mr. Bill Walker: If I may—

The Chair (Mr. Ernie Hardeman): That's the end of the time. The rest of it will go to the third party: Mr. Hatfield.

Mr. Percy Hatfield: Good afternoon, Mr. Chair. I haven't said good afternoon to you this afternoon.

The Chair (Mr. Ernie Hardeman): Good afternoon.

Mr. Percy Hatfield: Dr. Bell, earlier I believe you said that 6% of people in Ontario—it's in the Auditor General's report—lack family physicians. That was then; I'm just wondering what the number is now and what we're going to do to fix it.

Dr. Bob Bell: Yes. If we look across all the 14 LHINs in Ontario, the average is, to turn the statistic around, that about 92% of folks have access to a primary care doctor they consider to be their own. The issue is with the remaining 8%. Many people don't want a family doctor; young males in particular, prior to middle age, don't tend

to want a family doctor. So the issue is the proportion of people who want access to a family doctor and don't have access to them.

The other issue is that many people in urban environments choose not to go to a family doctor; they choose to go to walk-in clinics to get access to their medical providers.

Mr. Percy Hatfield: Do they choose to do that or is that their only option other than going to emergency?

Dr. Bob Bell: I'd say that, quite often, folks do have a family doctor but they don't have the access they want to their family doctor. An appropriate standard of care is that if you're sick and you feel like you need to see your family doctor, you should be able to see him within 24 to 36 hours. If you're busy, if you have a young family and you don't want to wait, it may be easier to go to a walk-in clinic than to wait for three or four days for a family doctor.

We have two issues right now. One is the maldistribution of family doctors to get that last few per cent who want it access to a family doctor. The second, and probably more important to this point, is to have a model of practice in family medicine that says, "If you want access to your doctor within 24 to 36 hours, you should be able to achieve it." That's probably the bigger challenge, I think.

Mr. Percy Hatfield: I believe you mentioned that we still have a shortage of psychologists and psychiatrists. What are we going to do to attract more of those specialists, especially for children and youth?

Dr. Bob Bell: Yes; great question. That's where Suzanne's relationship with the Council of Ontario Faculties of Medicine is so important, because that's where the target is set for the number of psychiatry training programs, for example, that we're going to be admitting postgraduate medical graduates to. That's one of the issues.

The other issue is to ensure that our psychiatrists, like other members of the interprofessional mental health team, are being used appropriately. There are a lot of different roles that can treat mental illness. There are social workers, nurses—a variety of different folks can. Psychiatrists tend to treat folks with severe mental illness that requires drug therapy; that's probably the role that they provide the best. Ensuring that folks with severe mental illness who need the services of a psychiatrist and also are seeing a psychiatrist within the team-based model is a change that we're making, but it needs to continue and happen faster.

Mr. Percy Hatfield: Are you aware of which regions in the province have the biggest shortage?

Dr. Bob Bell: Yes.

Mr. Percy Hatfield: Which regions are they?

Dr. Bob Bell: I can give you that information, with a little bit of time. There was a paper published by the Institute for Clinical Evaluative Sciences in Ontario that looked at the regional supply of psychiatrists about six months ago. In addition to the data we have—I don't have the numbers at my fingertips. I can tell you which has the best supply of psychiatrists.

Mr. Percy Hatfield: I don't think it's Windsor.

Dr. Bob Bell: No, it's not. The Erie St. Clair LHIN was actually one of the poorer- supplied areas; you're absolutely right. Child and adolescent psychiatry is a real need in that area.

Mr. Percy Hatfield: Why are there so many cardiac surgeons working as surgical assistants? Why do 34% of cardiac surgeons consider themselves underemployed?

1430

Dr. Bob Bell: Yes. Going back to the issue, I got some data on the issue of cardiac services in the Windsor region. As you know, Minister Hoskins announced $3.2 million for the extension of cardiac cath services when he visited Windsor in July, and I think that's going to make a big difference to the number of folks who need to go across the border when they're having acute cardiac conditions.

The number of cardiac surgeons working as surgical assists is an interesting issue. We probably have trained a few too many cardiac surgeons.

But going back to the issue of the rapid change in medical practice, there were a couple of papers published in the last three years that have demonstrated that, in patients with diabetes, the use of intravascular stenting procedures that unblock blocked arteries by the use of balloons and putting in little metal stents is probably not as effective as cardiac surgery for the management of diabetes. If the Auditor General were to repeat her review two to three years from now, we'd find that we may have a shortage of cardiac surgeons, and that diabetics, who constitute a huge proportion of patients with unstable heart disease, are now being sent back to the cardiac surgeon as opposed to having taxol-coated stents put in in the cardiac cath lab.

In these rare—not rare subspecialties, but in these narrow subspecialties, a small change in practice can mean an overwhelming shift in demand for human resources that can go from being a surplus to being a deficit in a short period of time. Right now, I think we're probably at about the right number of cardiac surgeons. I understand from colleagues that they're getting jobs now.

Mr. Percy Hatfield: We keep hearing the government say, "We're hiring a whole bunch of nurses." That little angel on my right shoulder says, "Good," and the bad angel on my left shoulder says, "If so, maybe, but why are so many working part-time hours or just casual hours?"

Dr. Bob Bell: Certainly part-time work is oftentimes that folks want part-time work. That's often the case with people looking after young families. They'll choose part-time work.

The proportion of full-time nurses in Ontario hospitals approaches 70%. I can't remember the exact—

Ms. Suzanne McGurn: We're at 64% right now.

Dr. Bob Bell: Is it 64%? Okay, I was wrong.

Mr. Percy Hatfield: I think, according to the report, that there were 15,576 hospital nurses working part-time and 4,552 hospital nurses just on casual.

Ms. Suzanne McGurn: Maybe I'll just add a comment. Early on in one of my answers, I reflected that we do collect over 50 elements of data as part of the membership renewal through our regulated professions. One of the pieces of information that is new this year is where people are able to indicate if they are in the type of work that they prefer and if they are seeking opportunities. We've had, in the past, conversations and evidence about people wanting to work full-time but never knowing exactly where the right percentage is. For the first time, we actually do have much more accurate information: Are people working in what they want—full-time, part-time or casual—and, of those, are they looking for other work in the next category?

It's a one-time piece of information for us right now, but we do hope, over the subsequent collection of that same information, to be able to better answer some of the questions you're raising about whether they are the wrong kinds of jobs or whether, in fact, the targets are reflective of what people's choices and preferences are.

Mr. Percy Hatfield: So at this point you haven't analyzed that? You don't have the numbers of people who say, "I'd like to be working more"—

Ms. Suzanne McGurn: We have one year's worth of information from the College of Nurses, yes.

Mr. Percy Hatfield: And have you analyzed it to say that a certain percentage of them want full-time?

Ms. Suzanne McGurn: We do have that information. I can't tell you off the top of my head. If you give me a minute, I might be able to find it, but that information is available. We're much closer to people's preferences, perhaps, than the targets that we've set at this point in time. Again, it's the first time, so it's a first point of data.

Mr. Percy Hatfield: It's not in the Auditor General's report, but I met with nurses recently, and they've asked me to raise the question of equal pay for work of equal value. You get trained as a nurse, you come out and you get some experience, but the pay scale is different if you're working in a hospital versus a long-term-care home, for the VON or for another community agency such as the CCAC, for example. They're wondering why, if you had the same training and the same skill set, the variations in pay are so varied.

Dr. Bob Bell: The model of work life in the community is complex, with a lot of different employment models. As I mentioned earlier, there are 650 contracts—more than that—that community care access centres have with health service providers in the community. The variability of unionized versus non-union work within those 650 contracts, the variation in benefits and pay, the variation in whether staff are paid for travel time between residences—you're right, there's an awful lot of variation.

I think it's fair to say that we've got a lot of that information together for one of the first times now, and we're analyzing that, as we really focus on home and community care as an area of priority, to try to better understand the variability and try to understand how we can bring some standardization to the community care area. I'd agree with you that it needs work.

Mr. Percy Hatfield: Dr. Bell, earlier you suggested that perhaps the best information available at this point might be 50 surplus orthopedic surgeons. I'm just wondering how we can exploit that. I mean, people have the skills, and if we want to reduce the wait-list—if you're waiting 11 months for forefoot surgery or nine months for cervical disc surgery, what would it cost for some of these surplus orthopedic surgeons to clear up the backlog of all those people waiting 11 months or nine months for surgery?

Dr. Bob Bell: It's interesting. My experience in cancer wait-time management and orthopedic wait-time management suggests that there is a preference for waiting in some things. I won't tell you that people want to wait a year for forefoot surgery, but if you've got nagging pain in your hip and somebody tells you that you're going to have surgery four to five months from now, that probably feels about right in terms of organizing your life and organizing the post-operative regime or rehabilitation you need etc., whereas if somebody tells you need a colorectal operation, you want that done. That's how our system is aligned. It's really aligned with wait times that reflect severity of illness.

You might say, "How well are we doing with that allocation of resource? Are we targeting it appropriately?" Probably one of the best ways to tell that is to look at patient outcomes. How well are our patients doing?

It's hard to get international comparisons on outcomes, but there was a very important publication in December 2011 that looked at outcomes for five of the most common cancer illnesses across western countries: England, the Scandinavian countries, three Canadian provinces including Ontario, Germany, France—about 10 different wealthier countries. Of course they couldn't compare the United States, because the basis for comparison was that it had to include all the patients in the population, and of course American registries only cover well-insured patients, or about two thirds of the population.

Members would be really pleased to know that Ontario came out on top of that comparison, along with Manitoba and British Columbia, for colorectal cancer, lung cancer, ovarian cancer and prostate cancer. We were at the top of the list. It suggests to me that we are targeting our resources appropriately for diseases where rapid access to treatment makes a difference.

We know that in 2001, when we were sending patients to Buffalo and Rochester for breast cancer radiation, we were not targeting our resources properly. But I'd say these patient-based outcome measures looking at survival from cancer suggest we are. I think that if we look at the Western Ontario/McMaster outcome studies for hip and knee replacement, our patients are not suffering from waiting up to six months for their surgery: 90% of surgeries are completed within six months. When we

look at the so-called WOMAC scores, we have some of the best post-operative WOMAC scores in the world.

I think the question is not so much how long you wait, although it's inconvenient sometimes. The most important question is, what is your outcome from care for surgical outcomes? I think we're targeting our resources pretty well, with close measurement of outcomes.

Mr. Percy Hatfield: I'm not really disputing that. I guess I'm just wondering: If you have an equation, if you have the number, many people are on backlog, on waiting lists for those two types of surgeries, and you have the 50 surplus orthopedic surgeons, can somebody come up with a number—I'll pull one out of the air: $1 million or $2 million—and then take that to the minister and say, "You know, you've got I don't know how many thousands of people who are waiting, but for a couple of million dollars you can clear that up." Is that a good political decision? Then it becomes a political decision, I guess, in adding more operating funding or operations funding to any given hospital or in more than one.

Dr. Bob Bell: You know, that question of resource allocation is one that goes on not only at the level of the Ministry of Health, but it goes on in the LHINs and individual hospitals, trying to figure out where the next incremental dollar gets applied based on the evaluation of patient need that's taken to the board on an annual basis as a governance element of what represents community need the most.

I'd say that if we looked at where the next incremental dollar should go in Ontario, it probably shouldn't go toward providing more—with respect, Sir—surgical care; it should probably go toward community care. We think that keeping people with complex medical diseases at home, in the environment they want to be kept in, is probably the place that needs the most attention.

Mr. Percy Hatfield: I wouldn't disagree, especially after hearing about all of the cutbacks and proposed cuts in service through our CCAC in Windsor lately. I think that's being resolved to some point, but there are still glaring examples out there that keep coming into my constituency office on a daily basis.

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes your time too, Mr. Hatfield.

Mr. Percy Hatfield: Well, good afternoon to you too.

The Chair (Mr. Ernie Hardeman): That does conclude the time that we have for this presentation. Thank you very much for taking the time to come in and talk to us. It will be of great assistance as they review the auditor's report.

Dr. Bob Bell: Thank you. I appreciate it very much.

The Chair (Mr. Ernie Hardeman): Thank you very much. We will just wait for a few minutes. We do have to have a briefing after this. If there are going to be discussions, if you could take them outside the door, that would be much appreciated.

The committee continued in closed session at 1443.

CONTENTS

Wednesday 3 December 2014

STANDING COMMITTEE ON PUBLIC ACCOUNTS

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Mr. Rudolph Chiu, director, Office of the Auditor General

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Ms. Erica Simmons, research officer,
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