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Tuesday 3 November 2009

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Mardi 3 novembre 2009

Standing Committee on Estimates

Ministry of Health
and Long-Term Care

Comité permanent des budgets des dépenses

Ministère de la Santé et des Soins de longue durée

Chair: Garfield Dunlop
Clerk pro tem: William Short

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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON ESTIMATES

COMITÉ PERMANENT DES BUDGETS DES DÉPENSES

Tuesday 3 November 2009

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The committee met at 0905 in room 151.

MINISTRY OF HEALTH AND LONG-TERM CARE

The Chair (Mr. Garfield Dunlop): We'll call the meeting to order. We would like to welcome Minister Matthews and all the staff from the Ministry of Health and Long-Term Care. We have two hours and 20 minutes remaining. Ms. Gélinas is not here from the third party. She actually had 10 minutes remaining. We'll go back to her and let her have that 10 minutes after. So we will start with the government members, and you have 20 minutes. Mr. Ramal.

Mr. Khalil Ramal: Thank you, Mr. Chair, and good morning, everyone. Good morning, Minister.

Oh, I can stop.

M^me^ France Gélinas: Sorry. There was a phone call.

The Chair (Mr. Garfield Dunlop): Are you prepared to start off?

M^me^ France Gélinas: Yes.

Mr. Khalil Ramal: I was preparing myself, France.

The Chair (Mr. Garfield Dunlop): Back to the third party, and you have 10 minutes.

M^me^ France Gélinas: These are my last 10 minutes?

The Chair (Mr. Garfield Dunlop): Yes. You've got 10 minutes remaining from before.

M^me^ France Gélinas: All right. Are you guys ready?

Hon. Deborah Matthews: Yes.

M^me^ France Gélinas: In my last 10 minutes I had started to question about long-term care, and I would like to continue in long-term care. Is there any way to find out the dollar amount that was spent on agency nursing in nursing homes and homes for the aged and by classification, as in not-for-profit and for-profit homes for the aged and charitable?

Mr. Ron Sapsford: I'm not sure. We can look to see if it's reported in that category. Certainly we would know by category of professional, but whether it's broken down by agency, we'll check and find out for you.

M^me^ France Gélinas: Okay, because under the new, second set of regulations under Bill 140, you allow nursing homes under 129 beds to use agency nurses in smaller nursing homes, and I was wondering if this is something that you have the intention of tracking.

Mr. Ron Sapsford: The permission around agency nursing has to do with the fact that sometimes it's difficult for small homes to actually find staff, and with the requirements to cover all homes with 24-hour nursing care, sometimes they need to resort to external agency staffing.

Yes, we have the data through an annual report. So whatever we have available certainly we could make available to the committee.

M^me^ France Gélinas: Okay. So will that be solely for this 24-hour requirement that I would get the agency nursing, or for other needs that the homes may have?

Mr. Ron Sapsford: The notion is that we want to have the homes fully staffed according to the monies that are provided and making sure that there's continuity in care, but as I've said, in certain cases where they have difficulty staffing—that could be over holiday seasons; it could be just general shortages in that particular community—it's more important to have staff providing the care than not. So we can certainly keep track of it on an annual basis and make adjustments if required.

M^me^ France Gélinas: So that data will be coming. Can I have the number of nurse practitioners who work within the long-term-care sector?

Mr. Ron Sapsford: Probably, yes, that would be part of the reporting.

M^me^ France Gélinas: Would you know their method of compensation? Is it always the same or are there different methods of compensation for a nurse practitioner coming into a long-term-care home?

Mr. Ron Sapsford: Each organization or agency would establish their own salary administration levels. I'm sure that's done with regard to what nurse practitioners are paid in different settings. But decisions about specific salary levels would be decided by that employer.

0910

M^me^ France Gélinas: I'm not interested in salary levels as much as I'm interested in methods other than salaries. Would there be sessional fees? Would there be—

Mr. Ron Sapsford: Oh, I see. Not formally by policy. Most arrangements would be by salary. It wouldn't prevent an employer, though, from arranging sessional payments if it was on an infrequent basis or the nurse practitioner only performs certain roles in terms of standards and training and so forth. But again, that wouldn't be set by ministry policy; that would be an individual decision.

M^me^ France Gélinas: If you can give me the number of nurse practitioners working within the sector, and if you know if there are payment arrangements—

Mr. Ron Sapsford: If there are differences?

M^me^ France Gélinas: Yes. I would like that.

I know that where I come from, lots of long-term-care homes are having recruitment and retention issues with nurses, and that brings up the issue of the 24/7 RN requirement. Do those nursing homes or long-term-care homes have to show you the efforts they've done to try to recruit if they're not going to meet the 24/7 requirements? Do we know how many there are? Do we know in what circumstances? Do we know what they do to try to meet that requirement?

Mr. Ron Sapsford: Not on a day-by-day basis, I wouldn't suspect, but as normal inspections proceed, staffing levels and so forth are part of the review. On the submission of semi-annual staffing reports, the ministry can then determine where staffing levels may have fallen. That's a follow-up discussion with the home, and the degree to which they're putting effort into it would be certainly part of the questioning that goes on.

M^me^ France Gélinas: Do we know the number of homes that have not met the 24/7 requirement for any period of time, let's say in the last year?

Mr. Ron Sapsford: I would suspect that going back through inspection reports we could determine that, yes.

M^me^ France Gélinas: Could you share that with me?

Mr. Ron Sapsford: Sure.

M^me^ France Gélinas: Thank you.

The next one: The Joint Provincial Nursing Committee and many other people have talked about implementing wage parity as a way to help the long-term-care sector with their recruitment and retention issues, specifically for RNs. Is this something that the ministry has looked at?

Mr. Ron Sapsford: Not specifically. I think I talked last session about the general issue of wages across the health care system and some of the differences that exist. We have done some examination to understand what those differences are, but there's currently not a specific policy approach to that.

M^me^ France Gélinas: Is this something that is forthcoming? Is it being discussed?

Mr. Ron Sapsford: The ministry hasn't brought that forward as an item to the government at this point.

M^me^ France Gélinas: Do you know if, in the budget we're in right now, there is transitioning funding that is available to implement the new long-term-care regulations?

Mr. Ron Sapsford: There is a small amount, yes, for the direct implementation of the regulations.

M^me^ France Gélinas: Do you know this amount, or can you tell me how to find it?

Mr. Ron Sapsford: Let me think about it, and I'll find that for you, yes.

M^me^ France Gélinas: Is it in the big book?

Mr. Ron Sapsford: That's what I'm not sure of.

M^me^ France Gélinas: Well, if somebody knows it?

Mr. Ron Sapsford: We'll tell you.

M^me^ France Gélinas: Sounds good.

Can I have the new funding model? And when will the new—I never knew how to pronounce this—RAI/MDS residence classification system for long-term-care homes be rolled out to all of the long-term-care homes? Will the new funding model follow suit?

Mr. Ron Sapsford: I think I'll ask John McKinley, the assistant deputy minister, to speak to that.

The Chair (Mr. Garfield Dunlop): You've got a couple of minutes left for this, and then it's back to the government.

Mr. John McKinley: I'm John McKinley; I'm the assistant deputy minister, information management and investment division.

The long-term-care piece of the new funding formula will be one of the later pieces to be added to the formula. First off, we only have the approval to go and use this methodology for planning at this point in time, but we are planning to take forward the decision on use to the government relatively soon, and we will follow on with the long-term-care stuff.

What we first have to understand, to use the information that comes from the MDS/RAI tool for funding, is that we have to make sure that the quality of the information is good and it does reflect what is actually going on in the homes; so that as we translate that into funding, it's a real reflection of what's going on in the homes.

M^me^ France Gélinas: Do you have a time frame as to when this will happen?

Mr. John McKinley: Not yet. We're still implementing the classification tool in the homes. We have all of them engaged at some point. Some of them have finished the implementation of the RAI tool, but a number of homes—about half of them—still have to go through the implementation of this. It does take quite a while—several months—to do an implementation in each home.

M^me^ France Gélinas: So no time frame as to when all of the homes will be done?

Mr. John McKinley: We have an estimated time frame of—I think it's about a year from now. But that depends on how well they do in meeting their milestones, going through the process and all of the other things.

The Chair (Mr. Garfield Dunlop): Thank you very much. We'll now go to the government for 20 minutes. Mr. Ramal.

Mr. Khalil Ramal: Good morning, again, Minister. My question is about an issue dominating the national and provincial media. People are concerned about H1N1. Today I had a chance to watch CBC news, and they were talking about the national concern, with the opposition in Ottawa accusing the government of neglect and not putting plans forward in order to address this issue. Of course, the opposition in the province of Ontario—same thing. They're accusing you and the government of lack of planning and not addressing the issue properly. We see on a regular basis that the media and many people are concerned about this issue. Can you give us an update on what's going on and tell us the latest news about managing this issue?

Hon. Deborah Matthews: Yes, I certainly can. As I think people here understand, the supply of the vaccine is the responsibility of the federal government. We are really focused on getting the vaccine that we have out and into Ontarians as quickly as we possibly can. We began last week, a week ahead of schedule. We've set a target to get all of the vaccine we have—2.2 million doses—out and into Ontarians by the end of day Saturday. Our public health units across the province are working very, very hard to achieve that target. The vaccine doesn't do any good sitting in a fridge. We want to get the supply we have into people as quickly as we can. Every public health unit across the province has a strategy. They are committed to achieving that target of using their supply by the end of the week.

We are focusing on those who are the highest priority first. It's very important that people respect the priority sequencing. Our health care workers: absolutely. We need our health care workers healthy. H1N1 hits little children the hardest so we're focusing on children six months to under five years, so up to and including age four. The caregivers of people who can't get the vaccination—for example, the parent of a small baby would be in a priority group, because a baby under six months old can't get the vaccine. So we're focusing on the caregivers, and caregivers of others who, because of health conditions, can't have the vaccine. Also included in the priority group are people under age 65—unlike seasonal flu—who have chronic health care challenges. So we've got the six groups. The sixth group is people who live in remote and isolated communities, and we have made special efforts to ensure that there's enough vaccine for them in their communities.

0920

When it comes to the supply, we always knew that there would be some degree of uncertainty in the supply. I have to say that when we received the news last Friday that the supply for this week would be significantly lower than we had anticipated, we had to revise our plan. So instead of going to a broader group of people this week, we're keeping the focus on those in the highest-priority groups. It's very important people that respect that.

Going forward, as I say, this week—and I think we now expect the supply late in the week—we'll get that vaccine out to our public health units as quickly as we can. We are expecting a supply of the unadjuvanted vaccine—that's the vaccine for pregnant women. We are expecting a good supply of that this week, and the health units will get that out to pregnant women as quickly as they can.

I have had conversations with the federal health minister, and I've underlined the importance for the provinces of getting the news as early as we possibly can about what supply we can expect, because we need to plan for the supply. As we get more vaccine, as the supply allows, we will be rolling it out to more people across the province. I am confident we will have enough supply of vaccine for everyone in the province who needs it and wants it. Of course, everyone who needs it and wants it, wants it now. We can't do that; we don't have the supply, but we will get it out as efficiently and as quickly as possible.

I think last week we did see some real glitches in the distribution; we saw people waiting far too long. I think we have addressed that problem. Public health units have responded to that big surge in demand, and I think what we're seeing now across the province are much shorter wait lines.

Mr. Khalil Ramal: Thank you, Minister. As you know, you set up a priority and you classified people to different levels, but still we see a chaotic situation in the communities across the province of Ontario. So what are you doing to communicate that with the people of Ontario—even though I heard a lot of messages from the media, and I listened to a panel from the United States that said that elder adults are almost immune from catching this one faster and quicker, so basically the focus is on children and babies. What are you doing to communicate that with the communities, to relax them and give them some kind of assurance that your strategy is going to work and everyone will get vaccinated, and they just have to respect the strategy in order to send it to the people who need it first?

Hon. Deborah Matthews: Dr. Arlene King is our chief medical officer of health for the province of Ontario, a world leader when it comes to pandemic preparedness. Dr. King is doing a lot of media. Every day, she is doing media availability—I go with her sometimes—so she's very much available to the media.

I think our website, ontario.ca/flu, is a very important vehicle for us. Not everyone, but most people do turn to the Internet first when they're looking for information, so we really do see that as a tool. We're linked to all of the public health units across the province, so someone can log on and find out exactly when the clinics are going to be, where they're going to be and what priority groups they are immunizing.

We're trying to use all of the tools at our disposal to get the message out to people: First of all, get the vaccine. H1N1 is a serious virus. We need to get as many people immunized as we can, but also to respect the sequencing to get the vaccine when they can. The other thing you should know is that in addition to the public clinics that we see the public health units offering, we now have over 2,000 locations across the province—family health teams, doctors, community health centres—where people can get the vaccine. Before people go to the clinic, they really should check with their family physician, their primary health care provider, to see if they can get the vaccine there.

Mr. Khalil Ramal: Thank you, Minister.

The Chair (Mr. Garfield Dunlop): Go ahead, Mr. Brownell. You've got about 11 and a half minutes.

Mr. Jim Brownell: Good morning, Minister. It's certainly a pleasure to see you at the estimates. Unfortunately, I missed a couple of days with some personal health issues last week, and I didn't get to see the transcripts or even get a report from my mother, who

watches all this stuff. She does report, and that's what I'd like to talk about.

First of all, before I talk about aging at home—I don't know how much of that was talked about here, but I'd like to bring up the issue again. I would like to preface that by saying that health care in Ontario today, despite the pressures and the concerns that we still have in addressing issues in health care, is better since we took office in 2003. You can see that first-hand as you go around our ridings. I'm going to give you an example. Winchester District Memorial Hospital, for example, one of my rural hospitals, never had a CT scanner. They have a CT scanner in that hospital now. Cornwall Community Hospital, with a capital project being built, will have an MRI machine. Our folks, myself included, had to leave the community to get the help and the supports for MRIs, and those people in the rural area had to go into Cornwall to get the CT scan. Things are better.

Having said that, I want to go on to the topic of aging at home, and I want to speak from a little bit of the experience of an individual who's probably watching the late show, she's probably watching the House right now, and that's my mom, whom you got to meet last year. You saw my mother in a wheelchair. My mother had some real issues: Hip surgery was required, and she has osteoporosis. She had to have a hip done for the second time this summer, and, while it was a huge operation and whatnot, she has now graduated up to a walker.

Despite having to go out into the community in a wheelchair, which she didn't want to do, she's pretty excited right now about all the supports. She told me the other day; she knew that I was in front of estimates and that you were here in front of us. She said, "You tell the minister that the supports that I'm getting are allowing me to stay in my own house."

I'll never forget the day that she left hospital. She was in for two and a half months because of this major surgery she had to go through this summer. The day that she arrived home—the day before, she was given a half-day out—I was at the house. It was just a sigh of relief when she could lie in her own bed. To see that: That's what Ontarians want. They want to stay in their own homes, they want to age at home, and she is aging at home. I see it. She said to me the other day that she can't believe it, and she's so thankful that there is this strategy; she didn't know a whole lot about it. I explained to her that we have committed quite a bit of funding to make sure that folks like my mother can stay in their own homes.

That brings me to the point. I just wonder if you could give us a breakdown. I think to myself that there must be a huge cost between these folks taking up the beds in the active hospitals and these folks now who are staying in their own homes and being given supports. She is being given a lot of help. I have to say, as a family, we are appreciative of that, the government doing that. But it's not just my mother; it's other folks out around my riding who are saying they are so thankful that they can stay in their own homes, they don't have to go into a nursing home, or they can be released from hospital a little bit faster.

So I'm wondering if you could talk about the current status of the aging-at-home delivery of service and if you could give us—I don't know if you have any statistics on the difference in funding. Do you have a funding-dollar figure with regard to the pressure it is taking off nursing homes and hospitals? That is my question, and I hope that you didn't mind hearing a little story about somebody very, very personal to my life telling me that this is happening in Ontario.

0930

Hon. Deborah Matthews: Thank you very much.

The Chair (Mr. Garfield Dunlop): You'll have to get the Hansard for her.

Go ahead. You have about seven minutes, Minister.

Hon. Deborah Matthews: Okay, and hello to Mrs. Brownell. We're glad you're feeling well, and we're especially glad you're watching us, because there aren't that many people who do and we're glad for any viewership here.

Mr. Jim Brownell: You're probably saying, "Get a life."

Hon. Deborah Matthews: No, not at all. I think the story you told demonstrates far better than any figures we could give you how important this aging-at-home strategy is. It's people exactly like your mom whom this is designed to help. I think you spoke so beautifully about the sense of wellness that she got from coming home, to be able to come back into her own home, with her own neighbours in her own environment, with her own comforts of home.

It's pretty hard to put a price tag on that. It's significantly better for her, but a lot better for the system too. I think that's why our focus on aging at home was a stroke of genius, because it's better for people; it's better for the system. It absolutely takes pressure off our hospitals.

You know we have challenges in hospitals. We have too many people waiting too long in emergency rooms. We have too many people in hospital who don't need to be in hospital, and by making these targeted investments to move people just like your mom from a hospital bed into her own home, that's where this is really paying off.

As our population ages, we're going to have to do more and more of this. We can't afford to keep people in hospital who don't need to be in hospital, don't want to be in hospital. We've committed $1.1 billion to our aging-at-home strategy over, I think, four years, and our LHINs are really rising to the challenge when it comes to developing and supporting the right combination of supports in their communities for people.

We know that as people age, their need for service ebbs and flows. In the case of your mom, she needed a certain amount of support, then she needs a lot more support as she recovers from her surgery, and then there may be a point where she'll need less support. So, we need to be nimble; we need to be providing the right amount of support at the right time.

For me, one of the really beautiful things about the aging-at-home strategy is that it takes advantage of all of

the resources in the community. It's not just strictly health care professionals who are engaged in our aging-at-home strategy. It's volunteers who deliver Meals on Wheels, who drive people to appointments. We're really engaging everyone in the health care of our elders, and I think that's a pretty remarkable thing for government to do, to provide a little bit of funding, to provide a whole lot of service for people who need it. I think it's the least we can do for people, and we know that if we don't do it, they will end up in our hospitals.

As I say, I think it's exactly the right thing to be doing. I'm looking forward to exploring how we can really continue to strengthen our aging-at-home strategy. The health care system is all linked together. It might be hard for some people to see the connection between your mom getting service at home and the wait time in the emergency room, but they're absolutely linked, because she's not in a hospital bed right now. That hospital bed is available for someone who needs the more intense services that can be delivered only in a hospital.

We've set targets for our emergency room wait time. We've set a target of four hours for less complicated cases and eight hours for more complicated cases. We've got work to do to achieve those targets, but we know what we need to do and we're doing it. We're taking those steps. Every hospital across the province has their wait times posted online. Anyone can go online and see the wait times in their hospitals and in other hospitals, and they can see the improvement in the wait times.

I think one of the things we've done well when it comes to health care is, we really have set in place the metrics so we can measure our progress. Whether it's wait times in emergency rooms or the reporting of infections or wait times on other procedures, we really are using the tool of measuring our progress, making strategic investments and reporting publicly on how we're doing. As we build a sustainable health care system, we're going to have to continue that work to determine what it is we're trying to achieve, put the measures out and report on those measures.

I can turn this now over to my deputy to add whatever he wants to this issue.

The Chair (Mr. Garfield Dunlop): You haven't left him much time, but you've got a few seconds, Deputy.

Mr. Ron Sapsford: Perhaps I can just talk briefly about the expenditures. In the estimates for 2009-10, there's an allocation of $223 million directed at the aging-at-home strategy. A portion of that, about $30 million, is for community care access centres, where some of the maximum numbers of hours of care have been increased. There has also been a change in the mix of services—more flexibility in whether it's nursing or other professional care. We've also extended the time for palliative care to be more flexible and to provide more care in the home.

On the community service side, there's an allocation of about $83 million to begin to invest in other kinds of care, particularly in supportive housing as well as other community services. There's an allocation as well of $15 million for assistive devices to give people the kind of devices they need in their homes to allow them to stay at home safely.

That's the allocation. Some of it has been directed to specific agencies, and then the local health integration networks have been accepting proposals from a wide variety of community agencies with innovative ideas about supporting people in their homes. They received 240 proposals, and about 205 of them are moving forward for implementation.

The Chair (Mr. Garfield Dunlop): Thank you very much, Mr. Brownell. Your mother would be proud of you for the line of questioning.

We'll now go to the official opposition. Ms. Elliott, you have 20 minutes.

Mrs. Christine Elliott: Good morning, Minister and Mr. Sapsford. I'd like to start with an issue that is important to a lot of Ontarians and particularly, I would say, to the residents of Durham region—I represent Whitby–Oshawa—and that's the issue of high-growth health care funding. I know that a large sum of money has been set aside. I can't recall at this moment; it's $100 million plus, I believe. I was wondering if you could please speak to the issue of how much has been spent, what it was spent on, how much remains and what the plan is for the remaining funds, please.

Hon. Deborah Matthews: I will turn this over to my deputy.

Mr. Ron Sapsford: Specific allocations in the current year related to high growth are directed at hospitals, and in the allocation there's $10 million. That's in addition to an allocation that was made in the previous year. The money is allocated to the local health integration networks, which then distribute it to the hospitals as part of their annual discussion. Other programs or increases in services are planned and implemented by the local health integration networks, so they're working on an annual basis on their specific plans and making decisions within the allocated funds as to which agencies receive it. That's part of their annual budget discussions with those agencies.

Mrs. Christine Elliott: Is it $10 million annually, then, that's going into it?

Mr. Ron Sapsford: Yes.

Mrs. Christine Elliott: How much of the fund remains?

Mr. Ron Sapsford: The allocation for this year is a $10-million base adjustment, so it goes into the funding on a permanent basis.

Mrs. Christine Elliott: That is going to continue—$10 million per year additional monies to be spent for the foreseeable future? I'm sorry; I'm not understanding.

Mr. Ron Sapsford: Yes. The allocation for 2009-10 is an additional $10 million. Whether that's to be repeated—in other words, to make it $20 million in the following year—will be a discussion that we'll have as we plan for 2010-11 funding. But that's the incremental funding that was put into this year's budget.

Mrs. Christine Elliott: And the money that has been spent in the past: Has that been done in the same way, rolled out in that way?

Mr. Ron Sapsford: Yes.

0940

Mrs. Christine Elliott: The next issue I'd like to talk about is the Ontario Association of CCACs. I understand that this group has been receiving over $20 million annually. Is that correct?

Mr. Ron Sapsford: I'm sorry. I didn't hear—

Mrs. Christine Elliott: The association of CCACs.

Mr. Ron Sapsford: Yes.

Mrs. Christine Elliott: How long has that been ongoing?

Mr. Ron Sapsford: Many years.

Mrs. Christine Elliott: Has that been an annual allocation for some years?

Mr. Ron Sapsford: I'm not at all sure we actually make an allocation—I'll have to check that—or whether the work of the association is funded directly by the CCACs, but I'll check that out.

Mrs. Christine Elliott: Are the CCACs—I guess this goes along with it—obligated to report to you on an annual basis for the funds that they receive, in a detailed manner?

Mr. Ron Sapsford: Before local health integration networks were in place, yes. But since local health integration networks have been put into place, the direct reporting relationship is between the CCAC and that local health integration network.

Mrs. Christine Elliott: And the information that you receive would then be through the report that's sent through the local health integration network.

Mr. Ron Sapsford: That's right. Yes. It's submitted to us.

Mrs. Christine Elliott: Can we obtain any information—I guess this might be to the minister—through the associations under FOI legislation? Can we get any information from them directly in terms of reporting?

Mr. Ron Sapsford: I don't think so.

Hon. Deborah Matthews: I have to tell you that I'm not sure we have a direct funding relationship with the Ontario Association of CCACs. I'm going to have to check that out. Normally, these umbrella groups are creatures of the groups as opposed to creatures of government.

Mr. Ron Sapsford: Yes. It has just been confirmed that we don't fund the association directly. So, consequently, freedom of information would not apply to that association.

Mrs. Christine Elliott: Is there any plan in the future, Minister? Can you comment on that? Is that going to be considered as part of the expanded FOI?

Hon. Deborah Matthews: Not to my knowledge. Again, I stand to be corrected, but I don't believe so, no.

Mrs. Christine Elliott: We've been told that some CCACs are asking their care providers to reduce patient files by as much as 30%. Is that the case? Is there any kind of a directive that's going out? What can you tell us about that?

Hon. Deborah Matthews: Can you tell me what you mean by a patient file?

Mrs. Christine Elliott: Reducing numbers.

Hon. Deborah Matthews: Reduce the numbers of—

Mrs. Christine Elliott: Patients.

Hon. Deborah Matthews: —patients they are seeing?

Mrs. Christine Elliott: Yes.

Mr. Ron Sapsford: There would have been no directive from the ministry, so I'm not sure where that would have come from. They all operate within their annual allocation, so it depends if you're talking about the CCAC or the service providers directly. Sometimes, in the agreements with their service providers, as volumes change, they adjust the contract levels, which may be what is being referred to, but there has been no overall directive to reduce caseload.

Hon. Deborah Matthews: In fact, I would say quite the reverse. We are expanding home care, expanding the number of hours that can be provided to people, so that Mrs. Brownell, for example, can get the amount of care she needs to stay at home. Home care is very much part of our aging-at-home strategy, which, in turn, helps alleviate emergency room wait times.

Mrs. Christine Elliott: I'm not sure if this question goes to you, Minister, or Mr. Sapsford. Has the ministry purchased diagnostic imaging equipment or software through CGI/GE, which I understand is an American company?

Mr. Ron Sapsford: The ministry wouldn't directly purchase clinical equipment. You said, diagnostic equipment and—

Mrs. Christine Elliott: Diagnostic imaging equipment or software.

Mr. Ron Sapsford: Imaging equipment. No, not directly. The only thing that I can remember that may fall into that was, several years ago when there was an expansion in equipment, there was one tender that went out to purchase equipment for a number of hospitals. I believe the ministry was involved in coordinating it, but not the direct purchase of it, no.

Mrs. Christine Elliott: I've got a number of different questions here. I'd like to move on to a question regarding the Joseph Brant Memorial Hospital, if I could. My question is regarding the expansion and renewal plans for the hospital now. They first submitted their plans in 2007. It's now 2009, and the residents still haven't heard anything about what's expected here. This expansion and renewal would mark the first major change in the hospital's physical footprint since the 1970s. Minister, could you please confirm when the residents can expect to receive an answer regarding Joseph Brant's proposal and what it will be?

Hon. Deborah Matthews: I will turn the specifics over to someone who could speak to that particular hospital. What I can tell you is that we are in the midst of a massive capital program when it comes to hospitals. I believe the number is $5 billion, which is being spent

through ReNew Ontario to bring our hospitals back up to the standards that they should have been brought up to before we came to office. I think it's fair to say that there wasn't nearly the capital investment prior to our coming to office that there ought to have been. So we're playing catch-up, but we're moving as quickly as we can. In fact, that hospital construction is actually providing real economic stimulus in our communities as well as providing better health care for people.

In my own community of London, we have a lot of construction jobs that are a direct result of investments in improving our health care system. That particular project, I'll see if the deputy has any information about it; otherwise, we can get you a status update.

Mr. Ron Sapsford: The hospital's proposal is not yet formally in the implementation process. There are a number of stages of approval that a hospital proposal would go through. The funding that the minister mentioned has been allocated, so all of the hospitals that are moving forward for construction are aware of that now.

The proposal from Joseph Brant has been received and is in the preliminary discussions, but at this moment there has not been approval for the hospital to proceed through the construction process. The decision as to whether or not and when it might be put forward would be part of our discussions for next year's budget. There's a process that we go through with capital as well as operating, and the government will make decisions about what projects can be financed during the next fiscal year or beyond; often it takes a couple of years to move through the planning process.

At the moment, I think, we've received the proposal. Initial review would be going on, but there's been no decision yet to actually approve it and fund it in the current fiscal period.

Mrs. Christine Elliott: How many more steps would you expect that it would have to go through, in terms of the review, to be able to present it for the next budget cycle, if that were to happen? For example, would you expect it to have reached the stage where it can be formally dealt with next year?

Mr. Ron Sapsford: It's hard for me to say as I sit here, but I believe so. Usually the process the ministry goes through is, we take proposals from wherever they come from and then do an analysis in terms of relative priority. What kind of a project is it? How large or small? We have different categories of funding; for instance, health and safety reasons. If a roof is leaking, that has a different treatment than if it's a major redevelopment worth hundreds of millions of dollars.

It depends on what the project is, its relative priority, the age of the facilities and the kind of expansion the hospital would be proposing. Then we sort through that and present it for the government's consideration. Then a decision will be made as to whether it joins the list of programs approved for funding.

Once approved, there's then a detailed review of what the program is, the size and shape of the building and the services that are intended to be offered. Does it include a program expansion? That has an impact on operating funds, so it's not just the capital construction; it's also the increase in operating funds which have to be accounted for in the fiscal planning. Once all that approval is done, then it moves on to architectural design and the construction process itself.

There's the program piece, approval to move, then design and construction part of it, which is the major capital funding; and then, at the end of it, of course, the operating costs associated with a new building. All hospitals have a local share; there's a requirement for local contribution to capital projects, and so part of the review process is to ensure that the local hospital in fact has the resources to contribute towards their share of it.

0950

Mrs. Christine Elliott: How long, ballpark, would that process normally take?

Mr. Ron Sapsford: It takes several years from beginning to end. Of course, that depends, year by year, what kind of fiscal resources are made available by the government within our budget process. For many years, the capital allocations were relatively small, and as the ministry said, the government announced quite a major infrastructure development program, and so over the past three or four years, we've had hundreds of projects that have been moving through that process.

Mrs. Christine Elliott: Is it reasonable to assume in the case of Joseph Brant hospital that that might be considered? Are they getting to the end of that process now, so that they might be considered for next year's budget cycle?

Mr. Ron Sapsford: Of course, as projects finish, more join the line, so it's kind of a revolving list. As I say, as projects are finished there are always other ones coming forward. It's simply a question of sorting through that and matching up approvals with fiscal resources to do that, but as we receive them, they join that review process. How quickly they move through it is, as I've said, based on the analysis that's initially done by the ministry in terms of relative need and then the resources voted by the government to support it.

Mrs. Christine Elliott: Okay. I understand that in the case of this particular hospital they haven't had any physical changes for the last 40 years, and I'm wondering how compelling that is in terms of making the argument for the need for redevelopment at this point.

Mr. Ron Sapsford: Of course, age of facility is a significant part of the evaluation, as well as the needs of the community, so high-growth areas versus low-growth areas. There are a number of factors that are taken into consideration, but certainly age of the facility is one of the criteria that are considered.

Mrs. Christine Elliott: Just in that vein, then, you may be aware that the Whitby hospital, a part of Lakeridge Health Corp., has recently received approval to reopen the hospital following a fire that happened about two and a half years ago. I know that the money has been allocated now, but it will probably take another year for the hospital to be reopened.

That being said, it still really is just sort of putting a band-aid on a very old facility that probably only has, I would say, fewer than 10 years of life left in it. Is that something, then, that would be considered relevant—also being in a high-growth area—in terms of eligibility for a new hospital?

Mr. Ron Sapsford: Yes.

Mrs. Christine Elliott: Good. Thank you.

Another question that I had received from one of our members was about a meeting with a Lyme Action Group—I'm all over the map here.

Hon. Deborah Matthews: I'm sorry, what's it called?

Mrs. Christine Elliott: The Lyme Action Group.

Hon. Deborah Matthews: Lyme?

Mrs. Christine Elliott: L-y-m-e, yes. They've indicated that they've had a meeting with the ministry and the ministry stated they would be more action-oriented than previous administrations.

As you may know, their issue is that there are poor testing options for Lyme disease in Canada, generally, and in Ontario, particularly, and they're hoping that the province will bring contamination of our blood supply by tick-borne organisms to the table with other provincial governments and federal authorities.

They are quite encouraged that your ministry has agreed to consider the need for the Ontario medical community to develop a better educational approach to training doctors to become aware of the growing incidence of Lyme disease in Ontario.

So, Minister, could you please provide an update as to what progress you've been able to make developing a better educational approach and also training for doctors to become aware of Lyme disease in Ontario?

The Chair (Mr. Garfield Dunlop): You've got about two and a half minutes left.

Hon. Deborah Matthews: I won't need two and a half minutes to exhaust my knowledge on Lyme disease, other than I do know that one of the many new phrases that I've learned in my time in this office is "vector-borne disease"—did I get that right?

Interjection.

Hon. Deborah Matthews: That refers to diseases that are borne by insects. I do know that there is work being done. I would turn it over to someone to speak more eloquently than I can on this.

Mr. Ron Sapsford: I'm not sure how eloquently I can speak about Lyme disease, but we'll follow up and bring back a detailed note on your specific question.

The only thing I would suggest is that we have done some educational materials on Lyme disease, which are on the ministry's website. It's information for both the public as well as providers, and that's being communicated through the public health units.

I'll get the specific information and bring that back to committee.

Mrs. Christine Elliott: I'd be grateful for that. We have heard about that in some other committees recently, and there seems to be a growing incidence, so that would be most appreciated. Thank you.

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

Mrs. Christine Elliott: Just on the same note, many people, I'm told, have to go to the US for treatment. Do we have many treatment facilities in Ontario for Lyme disease?

Mr. Ron Sapsford: We wouldn't have separate facilities, and I'm not sure what the treatment regime is for Lyme disease. If you'll allow, I'll add that to the question and give you some information about what the treatment methods are and how that's provided in Ontario.

Mrs. Christine Elliott: Thank you very much.

The Chair (Mr. Garfield Dunlop): You now have 20 minutes, Ms. Gélinas.

M^me^ France Gélinas: Could you flag me after 10?

The Chair (Mr. Garfield Dunlop): Yes.

M^me^ France Gélinas: Okay, thank you.

Hon. Deborah Matthews: You're used to 10 minutes.

M^me^ France Gélinas: Yes, I'm getting used to this.

My next series of questions will have to do with hospitals and health care services that are delivered through hospitals. The first one is, I like Mr. Brownell opening up the importance of access, and he gave examples of CT scans and MRIs. The issue of access in the north is access to PET scans. The ministry has announced that for a list of nine conditions for which the trials have shown to be beneficial, people can now have access to PET scans. I was wondering: Where does the money to pay for publicly insured PET scans come from in 2009-10, and how much do you figure we will spend this year, since it just started a month ago?

Mr. Ron Sapsford: There are two components of it: the OHIP charge for the physician interpreting the results of it, and the technical part of it—the cost of the drug and so forth—is funded through hospitals. I'll find the exact number for the current fiscal year.

M^me^ France Gélinas: When the ministry decided to add PET scanning for a series of diseases to the insured services, how many PET scans did they foresee, and how much would that add to the hospital budgets?

Mr. Ron Sapsford: Previously, when the research studies were being done it was treated as research, and the hospitals were funding a portion of that directly through their own research funds, and the ministry was funding a portion of it as well. With the change to insured service, then the ratio of funding would change 100% to the province. So the incremental amount for the ministry was about 50% more than had been paid when we were under the research regime.

M^me^ France Gélinas: Fifty per cent of what? Do we have an amount?

Mr. Ron Sapsford: Yes.

M^me^ France Gélinas: I wouldn't mind having it in writing, anyway.

Mr. Ron Sapsford: That's fine. Over the three years, it's been about $5 million for the last two, and for 2009-10, it's $7.6 million in this estimate. That will probably

increase next year because we only funded it for a portion of 2009-10.

M^me^ France Gélinas: As I said, Mr. Brownell talked about access. Is there a plan within the ministry to give the people of the northeast access to PET scan technology?

1000

Mr. Ron Sapsford: There's not a direct plan at this point. Again, the cost of the machine is a local responsibility, so hospitals fund the cost of the PET scanner itself. The volume of PET scans is relatively small and contained, and the number of machines we currently have in the province is sufficient to handle the volume for the whole province. As far as the northeast is concerned, there remains the problem of travel, but where PET scans have been ordered, people would qualify for the northern travel program in terms of their access to those services.

Hon. Deborah Matthews: I would just like to add that my understanding is that there is currently no wait time for a PET scan, so we are meeting the demand with the machines we currently have.

M^me^ France Gélinas: Do we know the total capacity for PET scans in Ontario and what percentage of this is being used? Can we find that out?

Mr. Ron Sapsford: We could make a calculation, I suppose. I would say that we have lots of capacity—

Hon. Deborah Matthews: I'd agree.

Mr. Ron Sapsford:—in terms of the numbers of scans we're actually seeing, both for the insured part of it as well as for the research part of it.

M^me^ France Gélinas: Could I find that out? I would like to know our current capacity. I understand that the University Health Network is in the process of adding one, but what is the current capacity and what is the projected demand, given the nine conditions that currently qualify for insured service?

Mr. Ron Sapsford: That would be an assessment we would have to do, but I'm quite sure we could do it. Currently we've got 10 scanners in nine centres, so if you look across the country in terms of the infrastructure that we have for PET scanning, we are rich in infrastructure. But we could do an assessment in terms of demand for service and try to do some projections for you.

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

Could I have a list of hospitals that are projecting deficits for this year, 2009-10—by LHIN would be fine. Is that okay?

Mr. Ron Sapsford: Yes.

M^me^ France Gélinas: All right. What is the increase in hospital budgets for 2009-10, 2010-11 and 2011-12, if you have it—it's usually a three-year?

Mr. Ron Sapsford: The estimate for 2009-10 is the one I have. The total increase from all sources is $593 million over last year's estimate, which is a net increase of 4.2%. They received a 2.1% budget increase for the current year, and added to that would be growth, which Ms. Elliott asked about, specialty program increases as well as additional monies to increase operating budgets for new hospitals that are going through expansions—those kinds of additional expenditures. The full amount is 4.2%.

M^me^ France Gélinas: Do we know what the projected budget increase is for next year?

Mr. Ron Sapsford: Not yet. That hasn't been determined finally.

M^me^ France Gélinas: Has the 2.1% budget increase across the board rolled out to every hospital?

Mr. Ron Sapsford: Yes.

M^me^ France Gélinas: Could I have the names and a list of hospitals that have not signed their accountability agreement for this year?

Mr. Ron Sapsford: We could endeavour to find it. I think that, in discussions between hospitals and local health integration networks, in certain cases they've come to agreements to balance their budgets in the following year and have an agreement in place. As far as I'm aware, every hospital has something in place with their local health integration network on the point, but we'll provide the information.

M^me^ France Gélinas: I guess I could word it a bit differently: Which hospitals have accountability agreements that submit a multi-year plan in order to balance their budget? If there are some other outstanding issues, I'd like to know which hospitals, in which LHINs and what they are.

Mr. Ron Sapsford: Yes.

M^me^ France Gélinas: Okay. Can you give me a bit of an update on the status of the HBAM funding for the LHINs?

Mr. Ron Sapsford: It continues to move forward, and the ministry uses it in its planning for allocations to local health integration networks. The new phase that we continue to work on is how to use the formula in agency allocations and so beginning to use it to modify funding formulas, for instance, for hospitals. That's still in a developmental stage. There's been no specific decision to implement that part of it, but we're still very actively pursuing the use of HBAM for more general population allocations for health services.

M^me^ France Gélinas: Do we know when it would actually roll out to different parts of the health care system? I've heard for long-term care, in about 12 months' time before we're ready; how about in other parts of the health care system? We're talking about hospitals now.

Mr. Ron Sapsford: We're looking at a similar time frame—

M^me^ France Gélinas: About another year?

Mr. Ron Sapsford: My estimate would be 12 to 18 months, if we're going to implement it; the technical parts of it should be developed by then.

M^me^ France Gélinas: I've just been told that I'm halfway through. Time just flies.

There have been changes in some hospitals that used to have emergency departments and that now have urgent care centres. Could you give me the difference as to, if a hospital has an emergency department versus an urgent care centre, what are some of the services that are different and what are some of the support services in the

hospitals that need or do not need to be there from one model? I'm thinking like a lab 24/7 or that kind of stuff. You can do it verbally, but I would also like it in writing.

Mr. Ron Sapsford: The requirement for an emergency department and what it takes to sustain an emergency department really speaks to the medical and clinical services that are available to the emergency department 24 hours a day, seven days a week. In order to provide emergency services, one has to have a lab, radiology, particularly the operating room in emergency services, and then, physicians available 24/7 within an immediate response time.

So oftentimes the requirement for an emergency department is what goes on in the hospital behind it, and if it can't be sustained, either through lack of human resources—for instance, a hospital that doesn't have a surgeon available can't very easily operate a 24/7 emergency department.

The difference between the two is that an urgent care centre cannot receive ambulances. That, beyond hours of operation, is the most obvious distinction between an urgent care and an emergency department: ambulance traffic.

Where an urgent care centre exists with a functioning hospital within patient beds, there's really little change behind that in terms of service requirements for things like radiology and laboratory services to serve the in-patients in the hospital as opposed to the emergency room. That may be offered on an on-call basis, as those services often are, but they would continue to be available for the in-patients of the hospital.

M^me^ France Gélinas: If we look specifically in Fort Erie and Port Colborne, would those hospitals see their budgets decrease because they went from an emergency department to an urgent care centre? Are there savings to be made for the hospital?

Mr. Ron Sapsford: Those kinds of decisions are not really savings decisions. There may be some marginal decrease in cost because it isn't open 24 hours, but commensurate reductions in other areas of the hospital, at least in my view, do not necessarily follow.

1010

M^me^ France Gélinas: So those hospitals wouldn't necessarily see their own budget decrease because they don't have to support an emergency department anymore?

Mr. Ron Sapsford: No. In the case of Niagara that you've raised, that would be, first of all, a discussion inside the hospital within their allocation for all of those facilities. There may be some reallocation of funds that goes on, but the net savings to the Ministry of Health, for instance, would not be part of that discussion.

M^me^ France Gélinas: I would like those differences to be submitted in writing, if possible.

Mr. Ron Sapsford: Yes, sure.

M^me^ France Gélinas: Thank you. Also, do you keep track of the services that have been able to be moved from hospitals to the community? Is this something that we track? We look through the work of the LHINs who are starting to do their work—some of them are starting to do integration in moving hospital services to the community. Do we have a list of this and do we track that?

Mr. Ron Sapsford: Where those kinds of integrations are contemplated, the requirement is that the LHIN identify those as part of their annual plan in the reporting to the Ministry of Health, so we would certainly have that information made available.

M^me^ France Gélinas: Can I have that? I would like it for last year and this year.

Mr. Ron Sapsford: Yes. To the degree it has been identified, yes.

M^me^ France Gélinas: Sounds good. Thank you. I'm afraid of running out of time.

I'm going to go to the fiscal advisory committee. The first one is, do you know if every hospital in Ontario has a fiscal advisory committee?

Mr. Ron Sapsford: There's a regulatory requirement that they do.

M^me^ France Gélinas: Yeah, but do they? Are they active in—

Mr. Ron Sapsford: To my knowledge, they would all have a fiscal advisory committee, yes.

M^me^ France Gélinas: Do you know if each fiscal advisory committee has—it's also regulation 5(2), if you're interested, regulation 965—

Mr. Ron Sapsford: Yes.

M^me^ France Gélinas: —"request a list of hospital boards that have received recommendations from their fiscal advisory committee with respect to the operation and staffing of the hospital for 2009." All fiscal advisory committees are supposed to report to the board. Do you know if this has been done, and can we find out?

Mr. Ron Sapsford: The ministry wouldn't have that information. It would be a question that we would have to contact LHINs and hospitals to follow up on.

M^me^ France Gélinas: Right now, there are quite a few hospitals—61 of them, I think—that are facing a deficit. They're also looking at staffing. Their fiscal advisory committees are supposed to make recommendations to the board. I'm not sure if this has been done, but by regulation it was supposed to be done.

Mr. Ron Sapsford: We'll follow up.

M^me^ France Gélinas: Thank you.

Has the ministry ever considered making fiscal advisory committees into interprofessional committees? Right now, only physicians get to sit on those.

Mr. Ron Sapsford: No. Nurses participate in fiscal advisory committees as well.

M^me^ France Gélinas: Any other professions?

Mr. Ron Sapsford: That would be at the discretion of the hospital. I think the regulatory requirement was for nursing participation—front-line nurses and—

M^me^ France Gélinas: I made a mistake there because I'm skipping questions. I had switched to medical advisory committees.

Mr. Ron Sapsford: Oh, I'm sorry. That's a different subject.

M^me^ France Gélinas: Yeah. We're not talking about fiscal advisory committees anymore; we're talking about medical advisory committees and making those interdisciplinary advisory committees rather than strictly medical.

Mr. Ron Sapsford: The medical advisory committee is a statutory requirement. So any change to that would be a legislative change.

M^me^ France Gélinas: I realize that. I'm asking if this is something that could be contemplated by this minister.

Hon. Deborah Matthews: I'm certainly well aware that there are those who are advocating for that.

M^me^ France Gélinas: Okay. Is this something that you are considering yourself or—

Hon. Deborah Matthews: I always consider advice that I receive.

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

M^me^ France Gélinas: Quickly, I'm switching to the Lori Dupont inquest and the recommendation that was made following the inquest. Recommendation 1 said, "There should be a review, conducted on a priority basis, of the Public Hospitals Act." I was wondering if this had been done following the inquest of Lori Dupont. That was recommendation 1 of the report.

Mr. Ron Sapsford: About the—

M^me^ France Gélinas: The review of the Public Hospitals Act.

Mr. Ron Sapsford: I'm sorry. I'm not sure what the recommendation was.

M^me^ France Gélinas: Actually, how about if I just ask and you can submit it in writing?

Mr. Ron Sapsford: The response to the—

M^me^ France Gélinas: For how you're doing in responding to each of the 26 recommendations. Of the 26, some have nothing to do with the Ministry of Health, but the ones that are directed at the Ministry of Health—just to let me know how far ahead we're going in implementing the recommendations.

Mr. Ron Sapsford: Yes, we'll do that.

M^me^ France Gélinas: I'm short of time, so I would also like to know how many hospital capital projects are currently under way—if you could give me the names—and, of those, how many were from the old P3 model versus the new AFP funding.

Mr. Ron Sapsford: We can certainly provide the list. If I'm following your description of the old P3, there was only one hospital constructed in that way. The remainder are in the alternative funding model, but we'll get you the lists and be clear about that.

M^me^ France Gélinas: When you say "one," it would be Ottawa or it would be—

Mr. Ron Sapsford: I stand corrected: two.

M^me^ France Gélinas: Two.

Mr. Ron Sapsford: Yes, the Osler Centre and the Royal Ottawa.

M^me^ France Gélinas: Brampton Civic Hospital presently is open—the new redesign is open. They're at 479 beds. They were supposed to go to 608 beds and then to—where are they at? Are they ramping up to be at 608 beds, and if not, why not?

Mr. Ron Sapsford: The first phase was to move into the new hospital and to stabilize. As you're aware, there is a provincial supervisor at that hospital now working with the hospital around the financial and community issues that were raised some time ago. We've been working closely with the supervisor on questions of ramping up. There's currently a proposal to take the hospital to the next level. That would be additional operating funds. The exact level is currently under discussion. So the—

M^me^ France Gélinas: Okay, I'll have to interrupt because I'm going to run out of time. Where does the money to pay for the supervisor come from and how much do those people get paid?

Mr. Ron Sapsford: We work within provincial standards. It's funded by the Ministry of Health directly.

M^me^ France Gélinas: So it doesn't come from the hospital budget? The ministry pays for them directly?

Mr. Ron Sapsford: Yes.

M^me^ France Gélinas: I'd like to know how much we spent on supervisors and how many there have been for, let's say, the last three years.

The Chair (Mr. Garfield Dunlop): We can pick this up later on this afternoon.

Mr. Ron Sapsford: Mr. Chair, just to finish, if you would, the answer to one question, the long-term-care funding related to new regulations: In the current plan, it's $33.2 million for 2009-10.

M^me^ France Gélinas: Thank you.

The Chair (Mr. Garfield Dunlop): Thank you, Deputy. Thank you, Minister and staff. We'll recess now until after routine proceedings this afternoon.

The committee recessed from 1017 to 1555.

The Chair (Mr. Garfield Dunlop): We'll call the meeting back to order. We have 23 minutes for each caucus before we complete the Standing Committee on Estimates with the Ministry of Health and Long-Term Care. Welcome back, Minister and the staff.

We'll go right to Mr. Ramal. You've got 23 minutes to question the minister.

Mr. Khalil Ramal: Thank you, Minister, for coming back again. I have a quick question; I know many of my colleagues have very important questions to ask. I know people spoke about H1N1 and many different things—about funding of health care, long-term care, the aging-at-home strategy—but not many asked you about mental health services, which has been referred to as the poor cousin of health care in Ontario. Can you tell us what you're doing in this regard? How are you dealing with this issue? What's your strategy to deal with mental health issues in the province of Ontario?

Hon. Deborah Matthews: Thank you so much for the question, and it is one that is extremely important. I think that very often mental health is overlooked. The minister previous to me, David Caplan, made mental health and addictions a very important priority. I can tell you that I want to continue the work that he began.

Certainly, my experience in poverty reduction helped me understand that very important linkage between mental health and poverty, and how we really need to be there to support people who are facing mental health challenges so they can live a rich and fulfilling life to the best of their ability.

There's a new understanding that mental health has been ignored for too long. I think the focus on trying to eliminate the stigmatization around mental health is a very, very important initiative. So I'm very happy to be on the record as saying that continuing the work of Minister Caplan when it comes to mental health is something that I am absolutely committed to.

I think the best way to serve people is, whenever possible, in the community. Actually, if you look at what our government has done since 2003, we really have invested heavily in mental health services, to build capacity outside those traditional settings. I'm told that we've increased our spending by 70% on mental health.

The other really important piece of work that's happening right now in Ontario is the work of the select committee. I have heard that the committee is working extremely well—

Mr. Khalil Ramal: Who's that committee—I'm sorry, I didn't—

Hon. Deborah Matthews: The Select Committee on Mental Health and Addictions, chaired by Kevin Flynn. We have on it representatives from all parties. It is, as I understand it, an entirely non-partisan approach. They're listening to people, they're gathering information, and they will be recommending what we need to do as we move forward to provide the right supports at the right time for people who are facing mental health and addiction challenges.

1600

The previous minister also established an advisory group on mental health and addictions to provide direction on a 10-year comprehensive strategy. I really do think that that's the way we have to go. It will take time. Everyone who is familiar with the subject knows that if we're going to do this right, it will take time, but I think there's enormous opportunity for us to do much, much better when it comes to mental health in this province.

In my previous ministry, as Minister of Children and Youth Services, I became familiar with the services available to children. I understand that the select committee and the minister's advisory committee are dealing with both children and adults, and I think that's exactly the right approach.

Mr. Khalil Ramal: Thank you, Minister. I'll turn it over to my colleague here who has a question.

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

Mr. Phil McNeely: My question just comes up to reinforce what Christine Elliott spoke to earlier today. This young lady came into my riding office about a week ago regarding Lyme disease. She was diagnosed with the disease and got treatment. She thought it was all over, that she was fine. The next year or two, she went to five specialists in the Ottawa area, and she kept getting worse. Eventually she couldn't walk. After the five specialists, some friend of hers said, "I know somebody in New York state. You should go down and see her." So she went down to this person in New York state.

She had brought up the Lyme disease several times in that two-year period with these specialists. One test was done, and it came back negative. She tried to get more tests done but couldn't get more tests done. Anyway, she landed in New York, and this doctor looked at her and said, "You've got Lyme disease." She said, "You've probably got this, this and this." There are two or three—is it viruses? Whatever it is. She sent away for the lab tests. I think the lab tests came from Texas, but in any case, within a week they were back and confirmed that she had Lyme disease, had these three things.

Her position with me in the office was that it was too late for her, but she's doing this for others. I think it is extremely important that we get up to date on this. This tick that spreads the disease is moving north with climate change. I think there are 25,000 cases in the States, so if we said 10% here—it might be the same number here. But our physicians cannot identify it; certainly, the five specialists in the Ottawa area couldn't.

I had written you a letter on that very recently, last week, but I'd just like to add that to the earlier concerns from the other member of this committee, and I'd just like to leave it with you.

Hon. Deborah Matthews: I would like to ask our ADM Josh Tepper to respond to the question, please.

Dr. Joshua Tepper: Thank you very much for the opportunity. I think you make a number of good points. As was raised this morning, Lyme disease, per the minister's conference this morning, is a vector-borne disease. It is something that is changing as the climate changes and as people travel more. It is certainly becoming more prevalent in Ontario. It is fortunately something that, when identified and identified early, can be well treated and treated at minimal cost with a well-established antibiotic. It is only in a select number of cases that it's either not treated or not treated early enough that a few of those cases can go on to have more significant effects.

I think the reality is, the ministry is actually quite aware of this. The public health units are very aware of this. There have been a number of reports. There is actually a vector-borne disease unit. They are doing a number of educational outreach activities with physicians, and that will have to continue in the public health units as well.

As somebody who works in a lot of rural areas in this province, I know that the education has been increasing for physicians quite consistently. I guess I would view this, as with other diseases that come and go, that ebb and flow and that increase, as a matter of physician education, nurse practitioner education, people at the front lines of care. I think our public health units are taking that extremely seriously and a lot of education efforts are under way.

The good news is the recognition of it once you're accustomed to it. The rash in question is a classic bull's

eye, something that, once you're triggered to it, you can quickly identify and, like I said, treat quite easily. But again, it's part of the ongoing education that all physicians do. Our public health units are pushing it.

Now that I'm working in a more inner-city population, the public health unit has been reaching out to educate me about, for example, multi-drug-resistant tuberculosis and leprosy, which again are now diseases—and malaria, as people travel more and more and come back. These are things that, as a physician who has now moved from a rural to an urban centre, as a front-line clinician, the public health units and the government have helped to bring me up to speed on, those pieces.

I think people can be comfortable that physicians take the diseases that change in their community very seriously and that the public health unit, the ministry in general and groups like the Ontario Medical Association, the Ontario College of Family Physicians, and the University of Toronto continuing medical education or continuing professional development department all take these types of activities seriously and engage in ongoing activity.

Mr. Phil McNeely: Thanks very much. The identification was made properly. The treatment wasn't proper; then, after that, the labs weren't making the right tests. So I think it's a very serious issue, but thank you very much.

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

Mr. Phil McNeely: Mr. Delaney, yes.

Mr. Bob Delaney: Thank you very much. If we're the ones giving you this amount of grief, I can't imagine what the rest of the people give you.

Last month, when the Auditor General released his report on Ontario's electronic health records initiative, I didn't have a paper copy, but I downloaded it right away and I read it with a great deal of interest. Although the 1980s doesn't seem like all that long ago, back then, in the mid-1980s, I started working for a company that was involved in software development. Since then, I've had some sort of a connection with the business in various forms. So I looked at it very much from the vantage point of one who has actually learned to, as the tongue-in-cheek expression goes, program in anger.

As I read it, I was never really sure of the scope or the breadth of the project. As the Premier has very clearly said, we as a government came up short, and we accepted every recommendation in the auditor's report and will implement every recommendation. But what surprised me was how much work had been done.

As I read through it, a lot of the things that—as I watched the issue evolve, I thought to myself, "Well, have we done..." and I would rhyme off a number of things in my mind. I was very surprised to find that, for example, the proprietary network onto which a user has to, first of all, be authenticated—in other words, you are who you say you are—and then authorized, which is, "Are you, in fact, authorized to go in and use this application, access this data?"—I was surprised how much of that was in place.

As well, with the applications, about which the auditor says some are doing better than others, I was again surprised at how many of them actually do exist. In taking the auditor's numbers, one finds that, for example, once implemented, the system under development will save the province of Ontario $2 billion each and every year, which puts the investment in the system into some sort of context.

For example, to look at the things that the auditor refers to—the client registry, the provider registry, the diagnostic imaging system, the drug information system, the laboratory information system, and the list goes on—it's encouraging, I think, to point out not so much where we came up short, which we admit, but how much has actually been done, how much value exists in the system going forward, and, as we put cars on this electronic highway, how much of a difference this is going to make in the quality of the treatment and the quality of the interface between our health care providers.

What I'd like you to comment on very briefly—maybe we can do a little back and forth on it—is a little bit of insight on where our government has actually made progress and perhaps what we can expect in the near and distant future.

1610

Hon. Deborah Matthews: I think you raise a really important point, and that is that the implementation of electronic health records is actually essential to a strong future for our health care system. So we're committed to moving forward as quickly as we can with the plan to bring electronic records to all Ontarians. I think that in the end, this will save us significant amounts of money. It will also make the system much, much safer for Ontarians as there's a more timely response and as we get safer prescribing and so on.

Perhaps I'll pass it to my deputy, and if you have other questions we can pursue those.

Mr. Ron Sapsford: I think you referred to a number of the elements that are under development that were identified in the audit report, and much of that work continues. I think the investment required to develop the system and to link together all of the health providers in all of their different locations is the challenge we face, so the various components, be it lab or diagnostic imaging, are essential components of that, and many of them are completed. For instance, on diagnostic imaging, all of our hospitals are moving to filmless technology so that the results of X-rays and other diagnostic information will be shareable, certainly at this point, among the hospitals and ultimately between hospitals and local physicians' offices.

Another major area that we're just beginning on is electronic medical records in physicians' offices. There are many physicians' offices across the province that still basically operate on paper record systems, and so if we're to have this kind of seamless information system, there need to be investments in physicians' offices as well as other agencies.

All of that work has different levels of investment, and they're on slightly different time frames, which was part

of the concern of the auditor: that some of these investments are a little out of sync. But with the new agency in place and their plan and time frame coming together, we now have a consolidated going-forward position, the government has made allocations, and I expect that we'll see significant progress on those files.

Mr. Bob Delaney: If one has ever programmed anything that's non-trivial in scope, you realize very quickly that in the development of an information system, as the expression there goes, "Process is everything." I read the auditor's comments on process, which we accept. I think good process, such as the auditor has suggested, is going to go an awfully long way toward taking some of the applications, which the auditor says perhaps could be further along in their development and coding, let alone in their beta testing and deployment, on that electronic highway that we have as a proprietary network.

Most businesses of far lesser scope and sensitivity routinely collect information from us. For example, a fast-food vendor can probably put together a mosaic of our behaviour as buyers based upon our interactions with them, and that profile is valuable to the vendor. In much the same way, the profile that will come together as we take the network, deploy the applications, convert or enter the data, and connect at the terminal end the health care providers—the doctors, the labs and whatnot—is going to enable Ontarians to gain the type of quick, timely, critical access to the details of our health records that, in some cases, are going to make the difference between life and death.

What I'd like to come back to is: What applications do we see as the priorities and which ones are furthest along and perhaps closest to deployment at this particular point?

Hon. Deborah Matthews: Let me just describe one that is up and running, and it's called the drug profile viewer. This is available in Ontario's 245 hospitals, and it holds the drug claim histories for all Ontarians who get their drugs through the Ontario drug benefit program, so that means all our seniors, all our people with disabilities on ODSP and all our people on social assistance. If they go into a hospital, a physician can, with a click of a button, see their entire drug history. I'm told by physicians who work in hospitals that this is enormously helpful to them. That's already up and running and really making a difference.

The suggestion that some have chosen to make that we spent a billion dollars and got nothing for it couldn't be further from the truth. We have made tremendous progress and really built the foundation for the electronic health record of the future that we will need.

Perhaps my deputy has more he'd like to add to that.

The Chair (Mr. Garfield Dunlop): You've got about three minutes for those comments.

Mr. Ron Sapsford: If I could just comment on the essential elements, I would say there are three or four components that are essential. One of them is drugs. The minister has talked about Ontarians on drug benefit programs. The object there is to expand it to all Ontarians so clinicians can access any Ontarian. Drugs is one component, lab information would be the second critical component, and diagnostic imaging is the third. The fourth we need, though, is the piece that links them together. That's the key to developing an integrated clinical record.

The lab system is well under way. We have the majority of private lab information and 50% of the hospitals. The drug piece requires additional work, and diagnostic imaging is well under way.

Mr. Bob Delaney: Indulge me for the last portion of this. Just before I was elected and for about a year or two afterwards, I would go down to the Microsoft campus once a year for one of their summit meetings. I was actually one of the first Canadians to be in that particular program. Basically, we were all under non-disclosure. They showed us everything; however, just about everything I know now is out of date.

But one technology I've used that I watched develop is pen-enabled data entry, which came out commercially as a tablet computer. I've actually seen this in use in Mississauga at a diagnostic lab. Everything that they have there is done using Wi-Fi, and it allows the lab technician or the doctor to use a stylus and a hand-held tablet computer that, using existing software objects, will allow the user to write as they normally would. The system can actually interpret a doctor's handwriting, which tells you how well it's programmed.

I swear to God there is a required course that teaches indecipherable handwriting in medical school; maybe you guys can tell me. I don't know, but I've always wondered.

What this does is on-the-fly, real-time data entry with error checking and reasonable quality assurance of the data going in that allows an electronic record, at their end anyway, to be stored with astonishing accuracy and of course, obviously, easily queriable, easily retrievable and, presumably, easily convertible.

Am I out of time?

The Chair (Mr. Garfield Dunlop): Yes.

Mr. Bob Delaney: Okay. Thanks.

The Chair (Mr. Garfield Dunlop): I thought maybe you wanted an answer.

Hon. Deborah Matthews: Tell us more.

Mr. Bob Delaney: No, no. I knew I was down to the last few minutes, so I said, "Bear with me."

The Chair (Mr. Garfield Dunlop): Okay. Thank you very much to the government caucus. Now we'll go to Ms. Elliott or Mr. Bailey.

Mr. Robert Bailey: Welcome, Madam Minister, and congratulations on your new appointment.

I have a number of questions here, so they're prefaced with some remarks. This is from the member for Niagara West–Glanbrook, who's unable to be here today. The residents of West Niagara are concerned that the new West Lincoln Memorial Hospital is once again facing LHIN-induced delays. You may be aware, Minister, that your predecessor, who recently resigned, was in Grimsby in 2005, when he was infrastructure minister, to announce this new hospital would begin construction in

2009-10. That contradicts what the Infrastructure Ontario agenda indicates, which is that the West Lincoln Memorial Hospital will in fact begin its new construction in 2011.

1620

Minister, will you commit to the residents of West Niagara that the new West Lincoln Memorial Hospital will in fact begin building in 2011 as scheduled?

Hon. Deborah Matthews: What I will commit to the residents of West Lincoln Niagara—have I got that right?

Mr. Robert Bailey: Yes.

Hon. Deborah Matthews: —is that their health care will continue to get better. We have made significant investments in that region and across the province to really improve the quality of health care and the accessibility of health care for Ontarians.

The LHIN, as I believe the member knows, is undertaking a clinical services plan in the area. This is a very important part of the process. There is a process and we are going to let that process work.

Mr. Robert Bailey: Further to that, the residents of West Niagara have done their part, thanks to the leadership of the West Lincoln Memorial Hospital Foundation, and apparently have raised over $13.5 million for this new hospital, yet the hospital board itself has been presenting to the local municipal councils and is encouraging the public to attend the LHIN open houses to voice their support for this new hospital.

Minister, if you and your ministry are keeping your commitments, why is there a push for local residents to come out and voice their support for this new hospital to the LHIN? Are these concerns by the residents and the municipal councils unfounded? Can you tell me what they have to be concerned about if you and the LHIN are fulfilling your commitments to them?

Hon. Deborah Matthews: This sounds more like question period than estimates, but hey—

Mr. Robert Bailey: You're doing a good job answering.

Hon. Deborah Matthews: Thank you very much.

What I'll reiterate is, first of all, it's wonderful when a community comes together to support better health care in their community. We see this happen, and I have to say that I really respect people who work very hard to raise the money they need for their local share of any hospital construction.

I will again say that there is a process under way in that community. I am delighted that there is broad participation in that process. That's the way it's supposed to work. Again, I look forward to that process working its way through.

Mr. Robert Bailey: Okay.

On to a different question: The Ontario Medical Association has asked that you and your government put on hold the major restructuring of health care services while your government, which has formed the rural and northern health care panel, does studies and makes their recommendations for health care in rural Ontario.

The region of Niagara, along with each of its 12 affected municipalities, also unanimously supports that OMA position. In that vein, a question: Why did you close the emergency room at Douglas Memorial Hospital in Fort Erie and why did they call for cuts in services at the Port Colborne hospital? Do you and your ministry still in fact refer to these institutions as hospitals?

Hon. Deborah Matthews: Let me speak to the importance of the rural and northern panel that's ongoing. I think all of us, whether we come from an urban area or a rural area, have a reasonable expectation of excellent health care. We also recognize, as health care becomes more and more complex and the services available to people become more specialized, that we have an obligation to retain the highest quality of care for everyone, whether they live in an urban area or whether they live in a rural area.

I'm absolutely delighted that we have in fact established a panel to really examine some of the challenges that exist in rural and northern areas. That work is now under way. I think it's important that we take a good hard and targeted look at that. So I look forward to the results of that work being done. It's one of many initiatives that is really focused on increasing access to care and improving the quality of care in Ontario.

If my deputy has anything to add—no? I've said it all.

The Chair (Mr. Garfield Dunlop): Ms. Elliott?

Mrs. Christine Elliott: In the brief time remaining, I may skip around a little bit, but I'd like to start with a few questions on out-of-country health services, if I might.

The first is a request for information, and I'm not sure whether to direct it to you, Minister, or to Mr. Sapsford. I was wondering if you would be able to provide us with a list outlining the number of medical procedures that were performed outside the country during the last fiscal period, the types of procedures that were performed and the associated costs with each procedure. Can that information be provided?

Mr. Ron Sapsford: I believe so. Certainly the cost is available. Whether it's categorized procedure by procedure, I'll check, but I believe it would be, yes.

Mrs. Christine Elliott: If you could provide that to me at your convenience, that would be great.

Can you tell me if there are any particular trends in terms of the types of procedures that are being ordered, or is there a wide variety in the requests that you're receiving?

Mr. Ron Sapsford: It's quite a wide variety. There is, of course, out-of-country for people who run into emergencies, and out-of-country for procedures that are not available in Ontario sometimes. We monitor that quite closely. I would say several years ago, there was a trend, if I can use the word, of people with acquired brain injury seeking treatment in the United States. The province made quite a concerted effort to invest in those services here in Ontario, so there has been quite a large reduction in out-of-country treatment for that.

The most recent one that has been identified is bariatric surgery. There was quite a large flux out of the country for bariatric surgery. There has been a concerted change in the investment in the province. We've started to invest quite substantially in Ontario hospitals to provide more access to bariatric procedures, and we're now seeing that trend reverse itself as well.

We do look quite carefully at out-of-country trends and try to identify where the clinical demand for services exists and what we then need to do to invest in and expand access in Ontario.

Hon. Deborah Matthews: If I could just add: When it comes to bariatric surgery, in the London Free Press, you will see ads on a fairly regular basis from a medical company in the States offering to do bariatric surgery there. They set up shop at a hotel. People come and sign up for the procedure. They go to the States and have the procedure. That's not acceptable.

There used to be bariatric surgery availability in London. That was cancelled under the previous government, and now we're spending $50 million or more a year on bariatric surgery out of the country.

Making that investment of, I think, $75 million over the next three years on an in-province bariatric surgery program is exactly the right thing to do. It also provides, of course, for much better follow-up care for patients who are going through that life-altering surgery.

Mrs. Christine Elliott: I've taken a look at the document called the prior approval application for full payment for insured out-of-country health services and have seen the criteria that are set out there. It doesn't really speak to the cost of the procedure. I'm wondering if you can tell me what steps are taken within the ministry to examine the cost of a surgery. If someone has come forward and said, "I would like to have X surgery and it's going to cost $70,000," what kind of analysis do you go through at the ministry in making a determination about whether somebody is eligible?

Mr. Ron Sapsford: Patients don't request directly. It's always physicians who are actually making the requests, based on clinical grounds.

We do several things. There's a clinical review or a physician review of the request. If a decision is made to refer out of country, we also attempt to negotiate prior agreements with health facilities in the United States which can provide that particular service. So rather than people simply being referred anywhere, we try to direct them to preferred providers where we have actually negotiated a specific charge for the kinds of cases that are involved. So in referring out of country, we try to get best value for that as opposed to simply sending people anywhere. Those are the principal techniques that we use.

1630

Mrs. Christine Elliott: What about in a situation where a procedure might be requested by an Ontario physician and an agreement hasn't been negotiated in another jurisdiction? What kind of analysis is gone through by the ministry in terms of determining the relative cost? Is there other research done with respect to the cost of alternate procedures or is it accepted at face value, the cost of the procedure that's being recommended?

Mr. Ron Sapsford: If it's an individual referral, I would have to say it's simply accepted. We don't stop to do an individual analysis for an individual patient who's being referred, so if the service isn't available at a place where we have a preferred provider, we don't stand in the way of that. The procedure would be done and then Ontario billed back.

Mrs. Christine Elliott: The other question I had just relates to some of the attendant costs relating to a person going to a different jurisdiction for surgery where accommodation costs, meals and so on aren't being allowed for. How does the ministry deal with that? If a person is otherwise eligible to receive the procedure but might not have the funds, is there any way that they can still be able to have the procedure done with those costs being covered, or will they be disqualified from having the procedure virtually by the fact that they can't pay for accommodations and meals?

Mr. Ron Sapsford: The accommodation?

Mrs. Christine Elliott: Yes.

Mr. Ron Sapsford: I'm not sure of the answer to that question. I can find out the details of that. My understanding, though, is that the cost of transportation for the patient is included, but I'll check on that particular point.

Mrs. Christine Elliott: If you could provide me with that information regarding accommodation, meals, and people who might otherwise not be able to have the procedure if that were not covered.

Mr. Ron Sapsford: Yes.

Mrs. Christine Elliott: If I could move now to a couple of other questions. One is, with respect to public health, can you tell me at this point how many medical officer of health positions are currently vacant in the province of Ontario?

Mr. Ron Sapsford: No, but I can get that for you quickly.

Hon. Deborah Matthews: I think you should know that there are no vacancies; we have acting medical officers of health in each of the public health units. There are some, though, that are "acting," but the positions are all filled, and trust me, we've needed every single one of them working very, very hard as we've prepared for H1N1.

Mrs. Christine Elliott: That leads me into my next question on H1N1, because there have been a lot of questions about the planning aspect of it recently. Can you tell me how much time the ministry has spent planning for H1N1? Do you have, first of all, detailed figures together with respect to time actually spent on the planning function?

Hon. Deborah Matthews: Are you asking for numbers of hours spent by ministry staff? I'm not quite sure what you're asking.

Mrs. Christine Elliott: Whatever level of information you can give me. I'm not sure what there is. If you could

tell me—what has been done to capture that information in terms of time spent planning?

Hon. Deborah Matthews: Deputy?

Mr. Ron Sapsford: We have a unit of people who are working full time on it. In terms of full-time equivalents, I could probably find that out, but hundreds and hundreds and hundreds of hours; there's no question at all about that.

Over the course of the summer, as planning continued around vaccine production, distribution and those kinds of questions, there has been constant work going on, in the ministry, in the public health units and between levels of government.

Mrs. Christine Elliott: Would you be able to make an inquiry, Mr. Sapsford, and provide me with that information?

Mr. Ron Sapsford: Yes.

Mrs. Christine Elliott: Thank you. Secondly, just with respect to some of the risk factors associated with H1N1—and you may not have this specific information at your hand—can you tell me what methodology was used to assess the risk associated with H1N1?

Hon. Deborah Matthews: Are you referring to the establishment of the priority groups?

Mrs. Christine Elliott: No, just in terms of establishing the total risk factors relating to how serious a threat it was going to be for public health. In terms of planning, what were the—

Mr. Ron Sapsford: Of the flu itself, you're talking about?

Mrs. Christine Elliott: Yes.

Mr. Ron Sapsford: That would come from population demographics. As public health professionals have watched the outbreak across the world, two factors: death rates from H1N1, and rates of hospitalization and serious complications. Based on those sorts of factors, judgment is made about relative risk: how quickly people recover, how ill they get, what proportion of the population suffers the flu but has a full recovery in a few days. It really looks at death rates and rates of onset as well as complications as a result of the flu.

Mrs. Christine Elliott: The next few questions relate to children and schools. Has the ministry set up a predetermined benchmark to assess, first of all, at what student absentee rate the ministry would advise closing schools? There have been some high absentee rates at some of the schools in the province. Has there been an assessment that has been done with respect to that?

Mr. Ron Sapsford: The approach that's being used is, those judgments are made locally, in consultation with the local medical officer of health.

The decisions about closure of the school have more to do with the ability of the school to continue to function, so the numbers of teachers and staff available to provide adequate supervision are some of the factors that are taken into consideration.

There's no fixed policy. The ministry certainly doesn't have a rule about when a school closes. Rather, it's made as a judgment between the school and the local medical officials.

Mrs. Christine Elliott: And are they required to report to the chief medical officer of health with respect to those figures on a periodic basis—daily, weekly?

Mr. Ron Sapsford: The figures—

Mrs. Christine Elliott: Figures with respect to outbreaks in schools, student absentee rates and so on?

Mr. Ron Sapsford: Specific outbreaks, yes. Part of the strategy is to identify where outbreaks do occur and then making sure that people are responding to those.

Mrs. Christine Elliott: I have a few more questions. I think I still have a few minutes.

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

Mrs. Christine Elliott: A few questions on family health teams: In the 2007 budget, your government said that 150 new family health teams would be up and running by the end of 2007-08. How many family health teams are currently fully operational?

Mr. Ron Sapsford: We'll find that for you. We'll ask Dr. Tepper.

Mrs. Christine Elliott: Okay, if you could provide me with that, I'd appreciate that.

Dr. Joshua Tepper: At least 148 of them are up and operational at this time. Of the additional new 50 that were announced subsequently, one of them has so far been announced and will be up and running, I believe, this winter.

Mrs. Christine Elliott: And do they all have a full complement of all of the health care professionals that one would expect to see on the team?

Dr. Joshua Tepper: Depending on the type of professional in question—and I can get you the breakdown by provider type—most of them are well over 70%.

Mrs. Christine Elliott: You expect that the additional 50 full-time teams will be up and running by when?

Interjection.

Mrs. Christine Elliott: The 50 additional that were announced. When do you expect that they will all be fully up and running?

Mr. Ron Sapsford: I think for the current year, it's a small number. The plan is for expansion in future fiscal years. The exact number for next fiscal year will be part of our budget discussions this fall.

Mrs. Christine Elliott: Has any consideration been given to augmenting the family health care teams with any mental health professionals? We're certainly hearing, in the select committee, a lot about the need to have more mental health professionals in the community. The suggestion has been made that the family health care teams might be a good place to place them.

Dr. Joshua Tepper: When the communities submit proposals, they are asked to submit suggestions—they actually provide a business case, including the types of providers who best represent the needs of their community. So a group of physicians and caregivers who see mental health as a major concern in their community will recommend a team that will include mental health

expertise in that area. They may see a high rate of diabetes in their community, for example, and may instead put in a mix of people who might be favoured a little bit more in that direction.

1640

I can quickly give you the numbers in relation to your earlier question, by the way, which are: nurse practitioners—75% have been hired; registered nurses—86%; RPNs—92%; dietitians—84%; mental health workers and/or social workers—89%; pharmacists—77%; educators—79%; and then any other health providers who are not included in that list at 68%, for an overall total of 83% of the anticipated number approved now hired.

I apologize; I was off by one. I said 148; it's 149.

The Chair (Mr. Garfield Dunlop): We've just got a minute.

Mrs. Christine Elliott: Okay. My final question is really in sort of a related field, mental health and addictions, relating to my previous question. I met with someone recently speaking about addiction programs and rehab programs. Specifically, as I understand it now, there are currently 21-day programs. Is there any indication that the ministry is going to be able to augment that and extend it to a longer period of time for a program? It's certainly a big issue that we've been hearing about in committee and from various other groups.

Hon. Deborah Matthews: What I can tell you is that we are very much looking forward to the report from your committee. I want to take the opportunity to commend you for your leadership in getting that going and for your ongoing role on the committee. I really do think it's an example of how members from all parties can work together for the greater good. I really do applaud the work you've done on that.

I think we all recognize that mental health is not something you go in for for 21 days, and poof, you're fixed. It's not like going in for a hernia operation; in many cases, it's going to be a lifelong challenge. Again, I welcome the work you're doing. As we move forward, we'll be informed so very much by the work you're doing.

The Chair (Mr. Garfield Dunlop): Thank you very much, Minister. Thank you, Ms. Elliott. The last rotation we have today is Ms. Gélinas. You've got 23 minutes.

M^me^ France Gélinas: Thank you. The next series of questions is going to be about home care. My first opening comment is that when Minister Smitherman was there, he had put a moratorium on the competitive bidding process for home care services. In December last year, Minister Caplan lifted the moratorium. My first question to you, Minister, is: Have you given any thought to reinstating the moratorium for competitive bidding on home care services?

Hon. Deborah Matthews: I will be perfectly honest and tell you that that topic has not reached the top of my briefing book schedule yet, but I will refer to the deputy for any comments he has.

Mr. Ron Sapsford: The whole process was reviewed and revised. There were stronger requirements put in for the process in terms of transparency and reporting. The minister of the day felt that the changes were sufficiently positive to move back into that competitive process, and that's currently the policy under which we're operating.

M^me^ France Gélinas: Again about home care: We know that CCACs have limits as to how many hours of care, how many homemaking hours you can get and how many hours of different levels of different services that they offer. Do we know what the total home care hours required are if we did not have those caps? I realize the caps are higher if you've just been discharged from hospital, and if you get the funding from aging at home, you get a little bit more. But have we ever looked as to what would be the real needs in hours for personal support for nursing etc.?

Hon. Deborah Matthews: So your question is, if we were to remove the cap altogether, what would the pressure on the system be?

M^me^ France Gélinas: Yes. Do we ever look at this?

Mr. Ron Sapsford: Yes. I think that the recent changes to expanding caps, as far as we're aware at the moment, have relieved pressure on patients who require higher levels of service. The bulk of the patient population requires average services, so the more intense or the longer it's required, there are fewer and fewer people who need that level of service. I think, in general terms, the change in the caps has made an improvement for that small group. But that's a question we will continue to monitor as time goes on to see if there are other adjustments that are needed.

M^me^ France Gélinas: When you monitor this, is this information that you can share with us? With me, anyway?

Mr. Ron Sapsford: If we have it, yes. Sometimes it's anecdotal. I'm not sure we get it in a consistent way that would answer your question directly, but to the degree that we've got information that answers that, we'll provide something to you.

M^me^ France Gélinas: One line of investigation is really to look at the cap that has been lifted with the new aging-at-home strategy. So how many hours of extra care were provided that wouldn't have been—that would be helpful to me—if we had kept the old cap? At least we'll have an idea of quantifying. If you have it per LHIN, I would be happy to have it per LHIN.

Mr. Ron Sapsford: It would be per LHIN, yes.

M^me^ France Gélinas: Yes, I would prefer to have it broken down by 14 LHINs. If it could be linked to the number of clients who have benefited, that would be helpful too.

Since the competitive bidding moratorium has been lifted and this has started over, how many new contracts have been tendered and for how much money?

Mr. Ron Sapsford: We'll find that for you. Since the new process was put in place?

M^me^ France Gélinas: Since the new process. Can I also find out, of the people who won those contracts, how many are not-for-profit and how many are for-profit, with the dollar amounts?

Mr. Ron Sapsford: I believe so.

M^me^ France Gélinas: The aging-at-home strategy has been talked about in estimates already. I think I can find in my little estimates books how much has been allocated for 2009-10. Do we know altogether how big that strategy is and how much of it was allocated for the first, second and third year? I think it was a three-year strategy.

Hon. Deborah Matthews: I believe it is $1.1 billion over four years.

M^me^ France Gélinas: And we are in year two?

Mr. Ron Sapsford: Yes. We're in year two. So, for 2009-10, in this estimate, $223 million; in 2010-11, $382.4 million; and 2011-12, $382.4 million.

M^me^ France Gélinas: And those were the original estimates for the entire strategy, and as far as we know we're still committed to those numbers?

Mr. Ron Sapsford: Yes.

M^me^ France Gélinas: Okay. In my constituency office, I often get people complaining about waiting lists for home care. Is this something that CCACs report on to the ministry or to the LHINs or to anybody? Do they keep track of their wait lists for rehab services, for nursing services, for homemaking services, the different programs that they have? How many people are on the waiting lists, and on average, for how long, by CCAC?

Mr. Ron Sapsford: It wouldn't be routinely reported to the ministry. The CCACs are responsible, though, for long-term-care placement. So when we hear about waiting lists with respect to CCACs, it's generally in long-term-care placement. Waiting lists for home care, I would suspect, is not an issue. Discharge from hospital and relatively immediate access to home care would be my expectation. There is information kept on waiting lists for access to long-term-care homes. That's kept by LHIN and it's kept by home. The CCACs have quite an active management of waiting lists for long-term care.

1650

M^me^ France Gélinas: I will get to this in a minute, but for now, I was not looking at placement; I was looking at—I can tell you that there is a wait list for rehab services in my CCAC. Is mine the only one and are they reporting on those wait lists?

I agree with you that for people who get discharged from hospitals, things tend to fall into place relatively quickly—often not as quickly as we want them, but relatively quickly. For people who are referred directly from the community in the Sudbury CCAC, the wait lists are very long. Are they an anomaly and do we keep track? Where do they report on that?

Mr. Ron Sapsford: Yes, for the wait lists for access, be they community or hospital as the source, we would. Most of their discussion about wait lists, though, would take place between the CCAC and the local health integration network. There's no formal reporting of wait lists directly from the CCAC to the Ministry of Health.

M^me^ France Gélinas: Okay, and that's except for replacement. Whether it's rehab or nursing, none of those are reported anywhere; they just—

Mr. Ron Sapsford: Correct.

M^me^ France Gélinas: It's too bad. We should document wait lists. It would help to identify areas that need attention.

The other one that I'm a little bit puzzled about—and I was wondering if it's specific to Sudbury: In Sudbury and in Sarnia, we have what we call home care clinics, which are when people on home care will go to the clinic to either have a complicated dressing changed or things like this. Are those common?

Mr. Ron Sapsford: They're becoming more common, yes. Rather than a nurse travelling to five different residences, sometimes the patients will come to a clinic together. In some cases, it's for activation of the patients themselves, sometimes there are social environments provided at the same time, or there's a complicated treatment involved. It's becoming more and more common, I would suggest to you, as an alternate way of providing non-hospital, community-based follow-up care and treatment.

M^me^ France Gélinas: And are the payments the same? It's a unit of treatment. Does the company that provides those services get paid the same, whether the nurse goes to your home or if they go to the nurse at the clinic?

Mr. Ron Sapsford: No. I expect that in the provision of the contracts, there would be a different pricing arrangement. But what that is, I'm not sure.

M^me^ France Gélinas: Is this something that is bid on competitively and independent? Like, the CCAC would ask, who is interested in running a home care clinic?

It seems a bit of an oxymoron, eh, "home care clinic"? But I don't know what else to call them.

Mr. Ron Sapsford: It's a good attempt—home care clinic.

It's probably part of the service requirements. When there's an RFP put out for service, a certain volume of service provided on that basis is probably part of the RFP. But I'd have to check into that to see exactly whether it's part of a broad service contract or whether they do it independently of the home visits.

M^me^ France Gélinas: While you look, if you could find out how many there are, I would be interested too.

Mr. Ron Sapsford: Okay.

M^me^ France Gélinas: All right. And if we have volume of service for those contracts, I would be interested in that too.

Mr. Ron Sapsford: Okay.

M^me^ France Gélinas: Thank you. Coming back to placements, my area has been on a 1A priority list for years now. The issue is now, if you're an ALC client, as soon as a bed becomes available, you will be transferred into that bed. In Sudbury, we have our person who's been waiting longest for a transfer to his home of choice for five years. Basically, what we tell them is that you have to take this bed when you're in a crisis 1A, so that means they get discharged from the hospital to the first long-term-care bed that becomes available, which is often not their home of choice, and then they pretend that they're on a waiting list to transfer to their home of choice. But because we've been in this crisis for so long, as I said,

the person who has been waiting the longest to transfer to his home of choice has been waiting for five years.

We have over 200 of those patients in Sudbury alone, and I think every single family member has come to talk to me because they are very unhappy. I could be busy in my constituency office just handling people who are not happy with their placement. Is there a willingness within the ministry to look at the situation created when a community has been in crisis mode for a very long time?

Mr. Ron Sapsford: This is part of the work of the local health integration network. I'm aware, certainly, that in the northeast, in that part of the province, this issue about access and resources is an ongoing part of their consideration.

There's not a specific move in the ministry to look at that particular policy. I think the policy is designed to place people at the appropriate level of care, so people in acute care hospitals who need to be placed in long-term care is the principle that we work from.

Then, as you pointed out, there's the issue about preferential placement in the home of choice, and at the moment, I believe it's based on three choices. People have to be prepared to accept one of those three placements from an institution. The objective is to move people to appropriate levels of care and then sort through, on a case-by-case basis, the question of preference of home.

We're looking actively at alternate levels of placement as well—supportive housing as another alternative, expanding the home care options, as we've already talked about—and providing more innovative care in the community to allow people to stay in their homes. So there's a whole series of initiatives that are at play here, but it is community by community, where there are issues around capacity at a particular level of care. These problems will come up.

M^me^ France Gélinas: I think I will bring this issue up through a different forum. It is something that is not working in my community, it's not working with the CCAC, it's not working with the LHINs, and they blame the ministry for not being able to move. You'll hear about this quickly, but in another forum. Stay tuned.

Talking about placement brings me to long-term-care homes. In the last request for proposal—and my memory fails me right now. I think it was about two years ago for about 3,000 beds. Don't quote me on this; I can't remember the exact numbers. From the last request for proposal, in the announcements that were made, how many of those homes are up and running and how many of those beds are up and running?

Mr. Ron Sapsford: We'll find that out.

M^me^ France Gélinas: It looks like it's coming.

Mr. Ron Sapsford: No.

M^me^ France Gélinas: Okay. So you will find this out?

Mr. Ron Sapsford: Yes.

M^me^ France Gélinas: Is there an intention at the ministry level to have another request for proposal for more long-term-care beds?

Mr. Ron Sapsford: There are, I believe, about 1,000 still remaining for request. The next strategy is redevelopment of some of the older homes, refurbishing of—the plan is for about 7,000 beds, but those are the existing stock, not new stock.

M^me^ France Gélinas: I didn't get what you said. You said there are about 1,000 remaining for request. What does that mean?

Mr. Ron Sapsford: There were the 3,000 that you referred to, and I think, in terms of the plan, we still have roughly 1,000 left.

M^me^ France Gélinas: Have they been allocated?

Mr. Ron Sapsford: No.

M^me^ France Gélinas: So how can communities apply for those 1,000 beds?

Mr. Ron Sapsford: At the moment, you couldn't. We have to go through that process of allocation.

M^me^ France Gélinas: And do you know when that process of allocation could be coming forward?

Mr. Ron Sapsford: No, not at the moment.

M^me^ France Gélinas: Can you keep me posted?

Mr. Ron Sapsford: Yes.

M^me^ France Gélinas: Okay. The per diem paid to long-term-care facilities—let's take one envelope at a time. Are there increases coming to the per diem pay to long-term-care homes?

1700

Mr. Ron Sapsford: For long-term care in the current estimate, the printed estimate is $3,159,000,000 and that moves, in this fiscal year, to $3,283,000,000. The components of that increase—the stabilization or the general increment—are about $39.5 million. There is a fund for acuity, so there are adjustments made based on the acuity level of residents in those homes, and that amounts to an additional almost $42 million. There is about $3 million for adjustments to the comfort allowance for the residents—this would be the amounts of money that individual residents have available for their own personal use—and about $5 million, which is the annualization for the PSWs who were added in the prior fiscal year. There were additional amounts put to complete the implementation of personal support workers. Then, as I mentioned to you yesterday, $33 million for the implementation of the new regulations. Those would be the increments for the current year.

M^me^ France Gélinas: It was this morning. It just seems like a long time ago.

Mr. Ron Sapsford: Yes. My apologies.

M^me^ France Gélinas: That's okay.

If we look at the CMM, the case mix, it has climbed by 4.23% to an average of 100.04. You've just told me now that there's $42 million that has been allocated. Is the money linked to the increase in case mix? What's the link between the two?

Mr. Ron Sapsford: There's an assessment done on a, I believe, home-by-home basis on an annual basis. It's allocated based on how the intensity measures vary home by home, and then adjustments made. So there is an effort to try to keep the acuity fund, at least, allocated in way that represents the changes in the care levels for a particular home.

M^me^ France Gélinas: So a home where an acuity level would have risen more will get more of an increase than a home that hasn't?

Mr. Ron Sapsford: That's correct.

M^me^ France Gélinas: Okay. As you know, I asked for the staffing levels on a regular basis.

Mr. Ron Sapsford: Yes.

M^me^ France Gélinas: We can see from the report that you gave me that there's a big difference between the staffing levels at not-for-profit versus for-profit homes. Is this something that your ministry looks at, and is this something where your ministry is interested in re-balancing? Often, the for-profit homes will have a higher acuity index than the not-for-profit, yet the staffing levels are lower. Does the ministry do anything with that information?

Mr. Ron Sapsford: I'm not saying it's in every single case, but in many cases some non-profits, particularly in the municipal area, supplement their funding beyond the per diems that are provided through the extended health care benefit, and that goes some way to explain some of the differences.

M^me^ France Gélinas: But not all of them are charitable municipal homes. Some of them are simply not-for-profit homes where the level of funding they get from the ministry is what they work with.

Mr. Ron Sapsford: That's correct.

M^me^ France Gélinas: But they are able to dedicate more of those resources toward staffing than in the for-profit sector.

The Chair (Mr. Garfield Dunlop): A minute and a half after this.

Mr. Ron Sapsford: The basic technique that we use is the inspection function, so ministry staff routinely inspect all homes—for-profit or non-profit—and look at the standards of care that are expected in the regulations to ensure compliance and, where compliance isn't achieved, then enter a process of discussion with the operator to ensure that that's the case. It's really a process of making sure that homes are in compliance with the regulation.

M^me^ France Gélinas: Okay. I'll ask a whole bunch of questions and you can just send me the response. Just nod as a yes or no, if you're willing to give me them.

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

M^me^ France Gélinas: The first one is: When will the Sharkey implementation committee report be released, and will it be released publicly? The next one is on the Casa Verde inquest: Can I have an update as to how many of the recommendations are being worked upon and have been successfully done? When will staffing information reported from long-term-care homes be on the public website? When can we expect this to start and to actually happen? And the same thing: When will the ministry begin releasing acuity data from the new computer system that you have put into place?

The Chair (Mr. Garfield Dunlop): You'll be able to get back to her with those answers?

Mr. Ron Sapsford: Yes, certainly.

The Chair (Mr. Garfield Dunlop): That concludes the time.

M^me^ France Gélinas: Did I use my minute?

The Chair (Mr. Garfield Dunlop): Yes, you did.

M^me^ France Gélinas: I still have a question.

The Chair (Mr. Garfield Dunlop): That's on top of the other three or four minutes you got earlier today.

Ladies and gentlemen, that concludes the Standing Committee on Estimates for the Ministry of Health and Long-Term Care. We have a couple of votes here.

Shall vote 1401 carry? Carried.

Shall vote 1402 carry?

M^me^ France Gélinas: I have no idea what we're talking about. What is that?

The Chair (Mr. Garfield Dunlop): The different sections of the estimates.

Mr. Bob Delaney: Just say "carried."

M^me^ France Gélinas: I don't want to say "carried." I want to know. What do 1401 and 1402 look like, and am I supposed to have a copy of this?

The Chair (Mr. Garfield Dunlop): No.

M^me^ France Gélinas: I'm not supposed to have a copy of that? Well, that settles that.

Interjections.

M^me^ France Gélinas: Sorry. Sometimes I'm confused.

The Chair (Mr. Garfield Dunlop): Shall vote 1402 carry? Carried.

Shall vote 1403 carry? Carried.

Shall vote 1405 carry? Carried.

Shall vote 1406 carry? Carried.

Shall vote 1407 carry? Carried.

Shall vote 1411 carry? Carried.

Shall vote 1412 carry? Carried.

Shall the 2009-10 estimates for the Ministry of Health and Long-Term Care carry? Carried.

Shall I report the 2009-10 estimates of the Ministry of Health and Long-Term Care to the House? Agreed.

Thank you very much, everyone, and thank you to the Ministry of Health and Long-Term Care, the staff and the Minister for a job well done. Thank you to all the members of the committee.

We're adjourned until tomorrow after routine proceedings.

The committee adjourned at 1706.

CONTENTS

Tuesday 3 November 2009