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Tuesday 3 November 2015

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Mardi 3 novembre 2015

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: Cheri DiNovo
Clerk: Christopher Tyrell

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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON ESTIMATES

COMITÉ PERMANENT DES BUDGETS DES DÉPENSES

Tuesday 3 November 2015

Mardi 3 novembre 2015

The committee met at 0900 in room 151.

MINISTRY OF HEALTH AND LONG-TERM CARE

The Chair (Ms. Cheri DiNovo): Good morning, members. We are here to resume consideration of the estimates of the Ministry of Health and Long-Term Care. There are a total of four hours and 12 minutes remaining.

Minister, do you or your ministry staff have any responses to outstanding questions from the committee that you would like to table with the Clerk?

Hon. Eric Hoskins: I believe there are a couple of specific requests that were made. My understanding is, my ministry is working on providing those responses, but, I think, nothing at this particular moment in time.

The Chair (Ms. Cheri DiNovo): Okay, thank you.

When the committee was adjourned last week, the third party was about to begin its turn in the question rotation. Madame Gélinas, please proceed.

M^me^ France Gélinas: Good morning. I was watching Canada AM this morning, and they were talking about trans people having problems of access. So my first questions will be about, partly, sex reassignment surgery, but trans health in general.

We've all known, and the ministry has known, that there are barriers that inhibit access to care for trans Ontarians. Important work has been done to build primary care capacity, but significant barriers continue to present access to publicly funded procedures for many trans Ontarians.

Myself, and the Chair of the committee, Cheri, have written to your ministry several times over the past two years asking that urgent action be taken to address the fact that, right now, 970 individuals are waiting for an appointment with CAMH for the gender identity clinic, which is the only clinic authorized to approve sex reassignment surgery in Ontario. We find out that the clinic has the capacity to approve less than 200 surgeries a year. I don't understand why we have only one site for preoperative approval. I have written to you a number of times. Every time, I get, "It's coming soon. It's coming very soon." But I haven't seen anything.

Because we are in estimates, I'm also interested in finding out if the $2.2 million reported by your ministry for sex reassignment surgery for 2014-15 is going to be the same amount going forward. Those are my questions.

Hon. Eric Hoskins: Thank you. I really appreciate this question. It's an important one. I know this is a very important issue for the Chair as well. She has represented the community extremely well on this issue, but more generally, as well, with respect to respecting our transgendered community and identifying for this government not only some challenges, but some work that needs to be done to improve access.

This is a very important issue for me personally, as well. I feel very strongly that this is an issue of respect and dignity and human rights. I'm proud of the work that this government has done in support of our transgendered community, but I recognize that, as you've identified, there is more work to be completed.

I'm also aware, when it comes to gender dysphoria, that it has potentially exceptionally grave emotional and physical implications. The rate of suicide among individuals who experience gender dysphoria is very high. The mental stress that individuals with gender dysphoria experience is enormous. That makes our obligation as government even greater.

You're right in indicating that CAMH, currently, is the sole site not for diagnosing or supporting individuals with gender dysphoria, but the sole site in the province currently with a program to approve, or pre-approve, sex reassignment surgery. To date, the surgery itself is not provided in this province. I think it's safe to say that that is an issue that also is of concern to me.

When the Chair, a number of months ago, raised this in the Legislature, and with me privately, as well, I asked the ministry to look not simply at the growing wait-list—I think we understand the wait-list over recent years has exploded, really, in terms of the numbers and the inability of CAMH as the sole site to be able to manage those individuals appropriately and in a timely fashion. So I asked the ministry to look at what support we might provide to CAMH, but more fundamentally our entire approach to supporting individuals with gender dysphoria who are considering sex reassignment surgery. I think, as you can appreciate, that required consultation first and foremost with the transgendered community and those health care professionals who are working to support it, including CAMH, but others—Rainbow, for example—across the province.

My goal in this is to provide an approach which is respectful of the individuals involved, recognizing as well the expertise that exists around the province to support these individuals—

M^me^ France Gélinas: So my question is: When? You say all the right words, but shouldn't that trigger an urgent response? I made the comment that there were 970 individuals waiting. That was in June. As of today, we're at 1,064. Every month, the list goes higher and higher. You already know that the risk of suicide, the risk of harm to themselves, is so high, and yet—I get a respectful answer from you, and I very much appreciate this, but I want to know when and I want to know money.

Hon. Eric Hoskins: Well, our transgendered community will not need to wait much longer. If it was as simple as providing additional funds to CAMH to reduce the wait-list—I mentioned that my belief is that we have an opportunity to transform our approach, to look at international guidelines, and other jurisdictions, but WPATH guidelines, for example, which are very sound and point to an appropriate process that would lead to supporting an individual to make that decision and go through with the surgery itself. I've asked the ministry to look at the issue of out-of-province surgery, and whether we have scope in this province for working to build that capacity in-province.

There are hundreds of individuals around the province who have the expertise to provide support to individuals with gender dysphoria, so I hope you can appreciate that in order to arrive at an approach which may be fundamentally different than our current one—for example, looking at the possibility of other sites or a different approach, which is health provider specific—that that takes some time to conduct that process responsibly.

M^me^ France Gélinas: It would be a whole lot easier to be patient—because all we get right now is that it's coming soon, but it was coming soon a year ago and it was coming soon in June. I wrote to you; you just wrote back to me last week that it was coming soon. Those words mean very little at this point.

It would be a whole lot easier to be patient if we could have proof that this work is taking place. If you are talking with the trans community, how come none of them know that you are talking to them? They're reaching out to us to find that out. If you are looking at building capacity, if you are looking at transforming the approach, where is this? Give me proof that this work is actually happening. Who's working on it? How many people? Where do they meet? What's the name of their group? Otherwise, it looks like you're well intentioned, but very little else.

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Hon. Eric Hoskins: You will have demonstrable proof in the very, very near future.

M^me^ France Gélinas: Does that mean before Christmas?

Hon. Eric Hoskins: Yes.

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

I will switch to the dental program, if you don't mind. We all know that, basically, you integrated six different dental programs into one. CINOT, Healthy Smiles Ontario, the social assistance program—all of these go and then the new program is starting. I'll start with a money question. How much funding was allocated to CINOT, Children in Need of Treatment, in 2014-15 and in 2015-16, and where can I find that?

Hon. Eric Hoskins: I think my deputy can help us with those specific numbers.

Dr. Bob Bell: Ms. Gélinas, in 2013-14, $15.83 million; in 2014-15, $15.8 million; and then continuing at $15.8 million for 2015-16.

M^me^ France Gélinas: And how much of that was spent?

Dr. Bob Bell: The new combined program, which has added $22.4 million to the budget this year—the total cost of the program in 2015-16, with the estimated new program costs plus current program costs, is $107.9 million for the integrated program. That's expanded service to 70,000 additional children and youth eligible for free dental service following the expansion in April 2014.

M^me^ France Gélinas: So CINOT was $15.8 million and has continued to be $15.8 million, but how much of the $15.8 million was actually spent?

Dr. Bob Bell: In 2014-15?

M^me^ France Gélinas: Yes.

Dr. Bob Bell: The combined program—I mean, the programs came together in April 2014. Minister, or ministers, correct me—over to you.

Hon. Eric Hoskins: The six—do we have those numbers? The actuals for 2014-15, broken out for CINOT?

Dr. Bob Bell: It was a third-party-administered claims-based program, so we don't have that information immediately available.

M^me^ France Gélinas: Will it become available after you do some hard work? Thank you for the hard work.

The same questions would apply to Healthy Smiles Ontario: How much funding was allocated in 2014-15, how much funding was allocated in the current year, 2015-16, and how much was spent?

Dr. Bob Bell: So the allocation: $27 million in 2013-14, increasing to $30 million in 2014-15 and onward. Again, understanding the expenditure—we'll have to come back with that data.

M^me^ France Gélinas: Okay. How many children were served by CINOT during those two years, and how many children were served by Healthy Smiles during those two fiscal periods?

Hon. Eric Hoskins: I think part of the challenge is, if I'm correct—I know our public health units work on the calendar year and ours is the fiscal year, so I've got the 2014 figures for CINOT.

M^me^ France Gélinas: Sure.

Hon. Eric Hoskins: CINOT paid for basic dental care for 31,435 children and youth with serious oral health problems. That's 31,435 who may have otherwise gone untreated. This total reflected more than 4,000 teens and 3,000 general anesthesia services for children five to 13 years as part of the program's expansion at that time.

M^me^ France Gélinas: That was quick. Do we have the same kind of details for Healthy Smiles?

Hon. Eric Hoskins: I suspect we do somewhere. For Healthy Smiles, I'm told that for calendar year 2014, there were approximately 70,000 children enrolled in Healthy Smiles. For 2015, we have an estimated 90,000 children enrolled. Does that help?

M^me^ France Gélinas: Yes, it does. Thank you so much.

I note that Accerta is now the one who will be handling the claims. Is their contract public as to how much it will cost the Ontario Ministry of Health to have Accerta take over?

Hon. Eric Hoskins: Thank you for your patience. I think you can understand that this is a level of detail that perhaps I might not immediately possess.

M^me^ France Gélinas: I don't blame you.

Dr. Bob Bell: It's not public as of yet.

M^me^ France Gélinas: Why not?

Dr. Bob Bell: I'm not sure. With the launch of the program, we anticipate this material will all become transparent and these numbers will be available.

M^me^ France Gélinas: Including how much money Accerta is making for doing their work?

Hon. Eric Hoskins: Yes.

M^me^ France Gélinas: Okay.

The Chair (Ms. Cheri DiNovo): Madame Gélinas, you have just over five minutes now.

M^me^ France Gélinas: Okay. Well, while I'm talking about the dental program, what will it mean for the health unit as to how much money was being transferred to the health unit that won't be transferred to health units anymore, once we transition to the new dental program?

Hon. Eric Hoskins: This is Roselle Martino, who is the ADM for public health.

Ms. Roselle Martino: Thank you. Health units are actually being kept whole, Madame Gélinas, during the transition year. The only money that will not be going to them as part of the integration is the fee-for-service, because they would pay, directly, fee-for-service dentists. Health units are not going to be paying that directly. Any money that they're saving from all the administrative burdens that they would do, we're putting that into client navigation. They know their clients best and they support a lot of priority populations and low-income, marginalized clients, so we're going to help them. Health units are going to be taking on that role of client navigation and supporting all the participants of the program to follow it right through. So we're not taking money away from them. The only piece was the fee-for-service aspect that will be going—instead of being paid by the health unit, it will be paid by the third-party administrator.

Hon. Eric Hoskins: Which was just a flow-through anyway.

Ms. Roselle Martino: Yes.

M^me^ France Gélinas: Okay. So the money that was going to the health units to do case navigation for children's dental, whether it's Children in Need of Treatment—the money stays the same?

Ms. Roselle Martino: Yes. They never had money in the same way for—a lot of their resources were going toward administration, doing forms and things like that. So that's where the third-party administrator will take that away and allow the health units to focus on what they do best, which is serving those low-income and marginalized populations.

M^me^ France Gélinas: Funny, because that's not what the health units are telling us. I mean, in Toronto, I have the Toronto Board of Health minutes, where they say it will mean the loss of one full-time and nine others.

Ms. Roselle Martino: Madame Gélinas, we have been communicating and we can give you some public communications. We have been telling the health units that they are being kept whole. We have stated that publicly, that they are not to let go of any staff, that the intention of this program is to keep them whole and focus on the client. They may have interpreted that, but that is not what the ministry has been saying and we have been communicating that quite consistently.

Hon. Eric Hoskins: It may be that there's an internal decision by a public health unit, given that they no longer have the substantial administrative burden, that they are no longer responsible for the fee-for-service flow-through, and they'll have an opportunity for a greater role in client navigation. It may be that there's an adjustment of the individuals working within, but certainly the funding remains whole, as my ADM has just told you.

M^me^ France Gélinas: Okay. So, along this line, when will the definition of financial hardship and the definition of clinical needs, which will qualify children for treatment—when will those definitions be known, made public and acted upon?

Ms. Roselle Martino: That would be a decision of our minister and deputy minister. We had a requirement to work on that and report that back, and what I will say, and then I'll defer to the minister, is that we worked with the health units and the municipalities on the definition of financial hardship as well as the definition of clinical need. So I'm very confident that we have been quite collaborative and got their input. In terms of when that will be communicated, I will defer to the minister on when he feels it's appropriate that that would happen.

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M^me^ France Gélinas: While I have your undivided attention, you are changing the way health units are funded. For 80% of them, that means being red-circled, as in, they're receiving too much money with the new funding formula. Can I have the list of the health units that have been red-circled, that are not going to get a budgetary increase?

Hon. Eric Hoskins: Certainly.

M^me^ France Gélinas: Can I have the money difference, the budgetary difference, between what it is that they are receiving now and what it is that the new funding formula is saying they should receive?

Hon. Eric Hoskins: I always want to say yes to you. Yes.

Ms. Roselle Martino: Madame Gélinas, just a bit of context, with the minister's permission: No health units received a cut to the base—

The Chair (Ms. Cheri DiNovo): I'm afraid we're going to have to stop there. Thank you very much. We're going to move now to the government side—

M^me^ France Gélinas: Just checking with the Clerk, does that mean that my request for information will be coming forward.

Hon. Eric Hoskins: Yes.

M^me^ France Gélinas: Thank you.

The Chair (Ms. Cheri DiNovo): To the government side: Ms. Kiwala.

Ms. Sophie Kiwala: My question this morning is for Minister Damerla. I have to confess that it's a little bit self-interested. As you know, my brother has very serious asthma, which was quite likely exacerbated and began when he was a full-time smoker. I am aware that this government has worked tirelessly to achieve the goal of making Ontario smoke-free. I know first-hand that we have come a very long way toward making that goal a reality; I can't tell you how much that pleases me.

Smoking prevalence has decreased from 24.5% in 2000 to 17.4% in 2014, representing 408,257 fewer smokers. But the use of tobacco products remains the leading cause of preventable diseases and death in Ontario. More than two million Ontarians still smoke and thousands of youth still take up smoking each year.

You know I have two teenage daughters. I am dropping off kids at high school when I'm at home, and have been doing so for a number of years now. My mother would say that it's soul-destroying to see groups of young children gathered in high school parking lots and playgrounds with e-cigarettes or smoking cigarettes. It's very disturbing.

So while we've made strides in reducing the number of Ontarians who take up smoking, I'm very interested in knowing how we're going to further reduce the prevalence of smoking, especially among Ontario's youth. I can't tell you how important it is to both me and many members of my constituency—and even among my daughters' social groups; they're very concerned about it as well. Thank goodness they don't smoke and they're not interested in it.

I would like to know what we're doing to decrease the smoking rates in Ontario.

Hon. Dipika Damerla: Thank you so much, MPP Kiwala, for that question. I really want to begin by thanking you for your role in so much of the heavy lifting that we have done so far legislatively in trying to reduce smoking in Ontario. You did a fantastic job on committee earlier in the spring and the entire team—I know you were the lead on that, so I really want to thank you. I know that this question comes from a very personal space for you; you are very invested in this and I just want to thank you for that. Thank you for your passion on this. Thank you for nudging this along and thank you for everything you've done to push our legislation forward.

You honed in on the issue of youth smoking. We're doing a number of things around youth smoking and trying to reduce that next generation from becoming smokers, really trying to stop that next generation of smokers. As you well know, the Making Healthier Choices Act, which we passed last spring, will soon hopefully—we're proposing that parts of it come into force on January 1, 2016. A big piece of that is the ban on flavoured tobacco, because we know that flavours are used to draw in youth, to draw in that next generation of smokers. Flavours make it easier for people to take up smoking; it reduces the harshness. When I say we are banning flavoured tobacco, I mean all flavoured tobacco, so that includes menthol. Now, there is a staggered implementation of the menthol, but it will also be banned. We are proposing for that a date of January 1, 2017. All in all, in the next couple of years, flavoured tobacco will be completely banned in Ontario when it comes to cigarettes and cigarillos and all of that.

I think that is a really big signature piece, but there is so much more we are doing on this file that I'm glad you asked this question. Beyond banning flavoured tobacco, the legislation also strengthens the Smoke-Free Ontario Act by increasing penalties for selling tobacco to kids, making these penalties now the highest in Canada. We are also strengthening enforcement to test for tobacco use in indoor public places.

Our government also has taken a responsible and cautious approach to protecting Ontarians, especially our youth, from potential harm by regulating the sale and use of e-cigarettes in public spaces, again through the Making Healthier Choices Act. We are again proposing that key pieces of the e-cigarette regulation come into force on January 1, 2016. That's what we are proposing. Should that happen, what will take place is that, effective January 1, 2016—if the proposal goes through—we would be banning the sale of e-cigarettes in certain places where the sale of tobacco is prohibited, such as vending machines and health care facilities. It prohibits the use of e-cigarettes in certain places where the smoking of tobacco is prohibited, such as enclosed workplaces and enclosed public spaces. Most importantly, it would prohibit the sale of electronic cigarettes to youth. That is really key.

The way we have crafted this legislation—it's really important—is to recognize that e-cigarette technology is new. There is the promise of the technology, but we also don't know all of the risks. So what we have done is taken a really balanced approach: We are not banning it; we are regulating it. Should, at a future point, the evidence conclusively point—to that e-cigarettes are cessation tools or could be used as cessation tools, our legislation is crafted in such a way that, through regulation, we can move very quickly to ensure that, if indeed e-cigarettes have harm reduction—and there's conclusive evidence—we can act on it to take advantage of that. So that's really important, that the legislation has been crafted with that kind of foresight.

I'm also proud to tell this committee that, as a result of many of these initiatives, the rate of young adults in Ontario age 18 to 21 who smoke fell from 33% in 2000 to 19.2% in 2013.

I would also like to take a moment to address how we are reducing smoking rates among Ontarians across all

age groups. As I've stated previously, our government has been working hard to toughen tobacco laws, ban smoking in public places, and has been trying and encouraging Ontarians to quit altogether. To accomplish this goal, my ministry has invested over $354 million for tobacco prevention, protection and cessation. We have listed smoking cessation drugs on the Ontario Drug Benefit Formulary and expanded access to nicotine replacement therapies for those undergoing addiction treatment.

While it is true that we have the second-lowest smoking rate in Canada, I believe we have a lot more work to do because I'd really like Ontario to have the lowest smoking rates in Canada and across North America. That is why our government is also committed to regulatory changes which prohibit tobacco sales on university and college campuses. That is already in effect. We have also prohibited smoking on playgrounds, sports fields and restaurant and bar patios. Again, these are changes that will protect young people as well as bar and restaurant staff from the dangers of second-hand smoke.

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Essentially, if you look at trying to reduce smoking in Ontario, we have to do two things: We have to stop that next generation from starting to smoke, and you will see in our legislation, the Making Healthier Choices Act, the number of provisions that do that, to help stop that next generation, whether it is the banning of flavoured cigarettes, whether it is the regulation of e-cigarettes or whether it is trying to de-normalize smoking by saying that you can't smoke on patios, you can't smoke around sports fields, restaurants, bar patios; the other part is to help people who want to quit, and that is why we have been investing in cessation.

So with these two twin tracks, we'll close the tap on one end to try and stop people from getting into smoking, and the other side being if you are already smoking and you're ready to quit, the government is here to help you quit.

Ms. Sophie Kiwala: Thank you very much for that response.

I started my question with a comment about my brother and his asthma and the health care costs that result when you have prolonged and chronic breathing problems. For instance, in his case—and this is just one story and I'm sure that both you and the minister have numerous other indications of more serious health risks down the road. In his case, he's been on very high doses of prednisone for decades and the loss of bone mass has been catastrophic. He's only two years old than me and he's had hip replacement surgery and can break ribs by coughing. Of course, when you have asthma, you are coughing a lot.

I can't tell you what it means to me to have this legislation. It's a very comprehensive piece of legislation, Bill 45, and I think it's going to prove to be very positive for the province in terms of our health care costs in the future. So I'm delighted about that.

I don't know if it's appropriate, Madam Chair, or not, but the last question we finished rather quickly. I don't know if your ministry staff would like to finish commenting on the last question. I don't think your staff was finished answering that. If we have a few minutes left—how much time do we have left?

The Chair (Ms. Cheri DiNovo): Almost nine minutes.

Dr. Bob Bell: Yes, if I could—just on the importance, Ms. Kiwala, of what you mentioned in terms of the impact of smoking not only on population health in Ontario, but the impact that it has on families and, crucially, the impact it has on the sustainability of the health care system. You've talked about asthma and chronic obstructive pulmonary disease. You'll be happy to know that the OECD is presenting data in the not-too-distant future related to the Ontario experience, and indeed keeping people out of hospital with chronic obstructive pulmonary disease and asthma is one of the ways the Canadian system does well.

The impact, however, on our hospital bed occupancy and, crucially, on the treatment of folks for a variety of forms of cancer, which is probably where the minister's work on reducing the prevalence of smoking in the Ontario population will have the biggest impact—most people recognize the impact that smoking has on lung cancer, but what they don't recognize is that the risk of several other cancers, including bladder cancer and colon cancer, is also increased by the risk of smoking. I think we tend to think about changing population behaviour to reduce smoking—it would take forever to demonstrate a change in those statistics of cancer prevalence.

The interesting thing is, in California, which introduced smoking cessation legislation and changes similar to Ontario's, within seven years of introducing those changes and seeing a change in the behaviour of the population, a reduction in the prevalence of people who smoke, there was a reduction in the numbers of patients who were diagnosed and treated for lung cancer. So this is not something that takes years and years to have impact.

Obviously, the prevention of any child or adolescent smoking is a lifetime health achievement, but even for people in the population who are current smokers, we recognize that stopping smoking at any time reduces the risk of cancer within that seven-year period for a population, as well as having dramatic impacts on the risk of having a heart attack or a stroke.

When we look at the changes in health behaviour that are fundamental investments in the future of our population's healthiness and the sustainability of our health care system, there's no question that reducing smoking prevalence is by far the most important element. If you compare it to the problem of being overweight, it's massively more important; even though being overweight is obviously important for health status, the impact of reducing the risk of smoking is dramatically even more important than that.

It also speaks to other healthy attitudes. There is data from public health information that demonstrates that people who are able to cease smoking tend to have other

healthier behaviours as well. People who stop smoking, generally speaking, tend to have better diets. They tend to exercise more. Also, people who don't start smoking also tend to have those types of healthy behaviours: exercise, eating fruits and vegetables, avoiding obesity. They tend to demonstrate those healthier attitudes, as well.

The Chair (Ms. Cheri DiNovo): Ms. Kiwala, you have just under five minutes left.

Ms. Sophie Kiwala: Thank you.

Dr. Bob Bell: So the impact of smoking and the importance of reducing the prevalence of smoking in our population is probably, it's fair to say, the most important thing that we can do to improve the health of Ontarians. We hear from the minister every week about how committed she is to this, and the number of ideas she has that we might use to tackle this issue.

Hon. Dipika Damerla: Thank you, Deputy. I think that MPP Kiwala might be interested in some numbers that also demonstrate what we have done in the cessation area. I've spoken extensively around the legislative tools we've used, but I do believe that we pay equal importance to cessation.

I'm happy to speak to the fact that since the renewal of the Smoke-Free Ontario Strategy in 2011, we have significantly increased the reach of services to help the people of Ontario to quit smoking, including over 61,100 smokers who received direct cessation support—that's counselling and referral for a quit attempt—through the primary care setting or through hospitals. Over 33,500 smokers received cessation counselling by phone, and over 26,900 accessed cessation resources online. Another 60,500 smokers received no-cost nicotine replacement therapy in combination with counselling. Over 11,700 young adults received no-cost nicotine replacement therapy, and over 10,100 young adults received cessation counselling by trained health care providers in post-secondary institutions.

Over 11,400 Ontario Drug Benefit recipients received smoking cessation counselling from a community pharmacy, and over 77,300 Ontario Drug Benefit recipients received smoking cessation prescription medications.

Smoking prevalence has decreased from 24.5% in 2000 to 17.4% in 2014. As you acknowledged earlier, that's 408,257 fewer smokers. I think that's 408,257 Ontarians who are living healthier.

In 2013-14, the government announced an additional $5-million allocation to Smoke-Free Ontario. The current allocation is almost $53 million. In the 2011 and 2014 platforms; the 2012, 2013 and 2014 budgets; and Ontario's Action Plan for Health Care, the government committed to reducing Ontario's tobacco use rate to the lowest in Canada.

One of the areas that I think we are really focusing on is that if you want and would like to see more Ontarians quit smoking, we need to be reaching out to as many smokers as possible. We need to reiterate the message that quitting smoking doesn't have to happen the first time you try it, because a lot of people try. It's very difficult; it's an addiction. So it's about that ongoing support that says if you tried once, that's fantastic. If you were smoke-free for even a week, you probably added—I don't know; I've got two physicians here. But even if you stopped smoking for a week, you've done something to help add to the quality of your life over your lifespan.

0940

It's to really go back and see how we can reach more Ontarians and help them quit and how can we send that message that it's okay to try and fail the first time, but just keep trying. If you try enough times, hopefully most people will get there.

There are many tools: There's counselling, there's do-it-yourself, there are support mechanisms, there's pharmacological interventions. There are many different ways here in Ontario. We really have state-of-the-art cessation supports, and we do our best to reach as many Ontarians as possible. I know that we'll continue to look at innovative ways of how we can not only reach Ontarians but, as I said, let them know that they're not in this alone. They have the supports, and every quit attempt counts.

I'm happy to answer if you have any further questions on this because I know this is an important topic for all of us.

The Chair (Ms. Cheri DiNovo): I'm afraid the government is out of time except for about two seconds.

Ms. Sophie Kiwala: I just wanted to thank you for your work.

The Chair (Ms. Cheri DiNovo): We will stop there. We will go to the official opposition: Mr. Yurek.

Mr. Jeff Yurek: Good morning.

Hon. Eric Hoskins: Good morning.

Mr. Jeff Yurek: I just want to pick up about the health units. My understanding is that 28 of the 36 health units' funding is frozen for an indefinite period. Is that about right?

Hon. Eric Hoskins: No. Our public health units, of which there are 36, were consistently informed since last year—again, it's a little bit challenging. Their funding cycle is based on a calendar year versus ours, which, of course, is the fiscal, ending March 31. In our discussions with public health units, we were consistent that they should expect a 0% increase this year.

However, based on a tremendous amount of work by my officials in the ministry, as well as a number of studies that have been accomplished with the public health community over a number of years, we had the opportunity to introduce a new funding formula for public health this year. The incremental increase, which this year is 2%—we used the funding formula, the new one, to allocate the increase of 2% to the global public health budget to those public health units that, based on the formula, warranted an increase. That formula does a much better job than the previous formula did in terms of allocating resources or at least pointing to a requirement to allocate resources based on public health need in the catchment area.

Mr. Jeff Yurek: So the documents I've read are with your new funding formula: 28 out of 36 health units will

have 0% increase until there's a balance with the other eight health units?

Hon. Eric Hoskins: It is as I described it. Historically, we provided a 2% increase to the public health budget; we've done that this year as well. However, in a model which took many, many years to develop with the sector itself and experts and reviews and studies, that 2% incremental increase in the public health budget, the incremental component, has been allocated to a specific number of public health units, which, by utilizing the new formula, indicated that they should see an increase in the funding. With the others, the formula did not determine that they should require an increase.

Mr. Jeff Yurek: So they're not getting an increase, the other health units, just a select few will get the 2% increase?

Hon. Eric Hoskins: Can you say that again? I'm sorry.

Mr. Jeff Yurek: Just a select few will be getting the 2% increase?

Hon. Eric Hoskins: I wouldn't describe it as a select few. I would describe it, based on the model that we took many years to develop with the sector itself and that enjoyed the confidence of the sector, as the incremental, the 2% increase, this year was allocated to those public health units that, through use of the formula, had a demonstrable need for increased funding based on the public health needs of the population.

Mr. Jeff Yurek: Is this a one-year hold on the 28 health units and, next year, do you expect all the health units to get the increase? Or are they frozen—

Hon. Eric Hoskins: I don't believe we've determined that on a go-forward basis, but part of the reason to focus on the distribution of the incremental increase—and remember, there is a 2% increase to the public health envelope in this province this year, as there has been in past years, but to mitigate any potential negative impact, we did not cut the funding or decrease the funding of any public health unit. We allocated the new, incremental 2% according to the new formula. That's what we have done this year and it hasn't yet been determined what our approach would be next year.

Mr. Jeff Yurek: Okay. Because my health unit in Elgin was just notified that they're frozen, six months into the year.

Hon. Eric Hoskins: It would not come as a surprise to them, because consistently, since last year, we had indicated to all public health units that they should expect a 0% increase.

Mr. Jeff Yurek: Sure. They're fine for this year; however, they're under the understanding that this is an ongoing freeze until there is a balance with the new funding model. Rural Ontario, where my main health unit is, and others throughout northern Ontario are left with trying to deal with how they are going to deal with the natural increase in the budget with salaries and benefits, when in fact the funding is frozen. Are the municipalities going to have to pick up the increase?

Hon. Eric Hoskins: I would anticipate that you would agree with the premise behind the new formula, which is to allocate the resources based on the public health need of the population. So those parts of the province where there is an identified demographic and other public health—where we are able, through utilization of the formula and the data that we have that goes into that formula, to determine where the greatest need is. I would hope you would appreciate that the increase in funding—we're not talking about the base funding that public health units receive, but the increase in funding—should be allocated to where the need is greatest, based on science and evidence.

Mr. Jeff Yurek: I'm not going to argue with you on that fact, but it seems to me that the health units that are now frozen are in rural and northern Ontario, which don't have the other resources to the health care system that, say, Toronto would have or London would have. Who's going to be picking up the gaps that will be created when the health units are no longer able to—they're either going to have to cut staff or cut services to maintain their budget.

Hon. Eric Hoskins: This was a formula that was developed over many, many years and a number of specific studies that went into it that engaged, in an exceptionally substantial way, the sector itself that we're talking about. We historically had a process where, really, without any forethought, without any consideration as to the actual public health need—and we had the data to demonstrate that need—we would provide across-the-board increases. As with what we are doing with our hospitals, where we are focusing more on quality and outcomes, we feel that it's a responsible use of taxpayers' dollars when we're allocating additional funds—and we're talking about the incremental, additional increase of 2% this year—that we have a formula, based on science and evidence, that can express the public health need of a particular jurisdiction. So the incremental funding—I think it's a responsible decision by government that would be supported by our taxpayers if that incremental funding would go to those who require it.

Mr. Jeff Yurek: When will these health units know if they'll be frozen again next year? When will you notify them for their budgeting purposes, so we'll know whether or not municipalities will have to pick up the slack?

Hon. Eric Hoskins: Roselle was a lot easier to turn to when she was there. Now she's disappeared to the back.

Dr. Bob Bell: Just while Roselle is coming up, I'll mention, Mr. Yurek, that this year we're also looking at a review of the Ontario public health standards to determine whether they need to be modernized, so the expectation that we have of public health units to work on mandatory programs, for example, will be reviewed in terms of best practices. We may be changing some of those standards, which may help to focus the work in the public health units and allow them to deal with their budgets.

I should say that the funding review working group that came up with the advice that we took to heart in

terms of the funding formula that we have used was strongly advised by public health, looking at issues like the socio-economic determinants of health, looking at population growth in various areas, looking at the cultural diversity of various areas—

Mr. Jeff Yurek: Sir, I don't mean to cut in. I know we're trying to eat up 20 minutes here, but the question was: When will the health units know if their funding will be frozen next year?

Hon. Eric Hoskins: They will be informed before the end of this calendar year.

Mr. Jeff Yurek: This calendar year. So by March 31?

Hon. Eric Hoskins: The calendar year, by December 31.

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Mr. Jeff Yurek: Calendar? Sorry. December 31. Great. Thanks.

Just moving on to the CCACs, I'm sure you've read the Auditor General's report, as I've read it. It noted that almost 40% of the budget is going to bureaucracy. You could argue that 40% down to 30%; still, that's a heck of a lot of money going to non-patient care. How long have the CCACs been operating with that high a percentage of money going to the bureaucracy, do you know?

Hon. Eric Hoskins: I know that the Auditor General looked at one point in time. Part of the challenge that she, herself, recognized and identified in her report was that there is not and has not been a consistent methodology behind measuring direct patient care or direct patient contact, and the differences between the two, and administrative costs and overheads. There hasn't been a clear definition—not just in our CCACs, but really that's a challenge that is faced across North America.

So she provided us with that definitional clarity. She looked, at one point in time, with definitional clarity that—as I mentioned, generally speaking, there's tremendous diversity across North America. It's difficult to say that that information would be available in retrospect without doing the sort of in-depth analysis that she did, given that she provided new definitions.

Mr. Jeff Yurek: So you have nothing in place to see what money is going to bureaucracy in the system?

Hon. Eric Hoskins: That's not what you asked, right? You asked if we had historical data.

Mr. Jeff Yurek: How long? So you don't have that data to know whether the money went to the bureaucracy.

Hon. Eric Hoskins: We certainly have historical data.

Mr. Jeff Yurek: Will you provide it to the committee?

Hon. Eric Hoskins: If you'll let me answer, we have historical data that articulates the nature of the expenditures of our CCACs, but you had asked me, and you gave figures quoting or paraphrasing the Auditor General's report, using a definition which—actually, she uses several definitions—

Mr. Jeff Yurek: What definition did the Ministry of Health use?

Hon. Eric Hoskins: I think that it would be our view—and I should say that I'm on record several times, as you know, welcoming and embracing and agreeing with every single one of the Auditor General's recommendations and have indicated that the government will be implementing all of them. So I've welcomed her report; it provides us with an extremely important road map. She uses a number of figures. She suggests at one point that, inclusive in those figures that you quoted, care coordinators would be included in that. I believe that our care coordinators are not administrative overhead—

Mr. Jeff Yurek: But if you remove the care coordinators, it goes down to maybe 30%, she was saying. So do you not think that 30% rather high for bureaucracy?

Hon. Eric Hoskins: But then she also uses another definition which brings it into the 80% range: when an individual—if their responsibility is to purchase or obtain a piece of medical equipment that's required for a home care patient. I would be of the view that that's not administrative overhead; that's direct patient care. So if you are prepared to accommodate that definition—

Mr. Jeff Yurek: That equipment goes through a contractor, so actually the contract is providing the equipment piece.

Hon. Eric Hoskins: No, that's a requirement within the CCAC, so that's not a third-party exercise.

Developing a care plan for an individual receiving home care: I don't believe that that's administrative overheard. As a health care professional, I believe that that's an important aspect.

Mr. Jeff Yurek: So what is the Ministry of Health's definition? What definition are you going to be following?

Hon. Eric Hoskins: I greatly appreciate the definitional clarity that the Auditor General has provided. We intend to act on her recommendation, which is, among other things, to do a full-system review to ensure that, through our CCACs, we are providing the maximum return on investment for the taxpayer dollars that are invested in that aspect of our health care system. Whatever definition we use, the Auditor General was clear in her recommendation that we can do better. So we'll continue to work with our CCACs to find those operational efficiencies—

Mr. Jeff Yurek: When do you expect to have that definition in place so that it's across the board, so that we can have an understanding going forward on what percentage of the money is going into bureaucracy? We can have an understanding so that the next time the Auditor General finds that almost a billion dollars is going into the bureaucracy—what definition are we going to use, so we can watch the trends of money in the system?

Hon. Eric Hoskins: I suspect that the Auditor General will make a decision to review the progress made in the future, so she'll have the opportunity to define those various costs as she wishes to. She has provided three different definitions: one for direct patient contact, one for direct patient care and then a broader definition. We have the data so that we can comfortably provide evidence of expenditures, regardless of which of those three definitions might be used.

Mr. Jeff Yurek: What target would you aim for? What target are you going to put in place so that CCACs have a

benchmark to reach with regard to how much money goes to administration?

The Chair (Ms. Cheri DiNovo): Mr. Yurek, you have about five minutes left.

Hon. Eric Hoskins: The ministry is in the process of—we've accepted and we're reviewing the Auditor General's report. We're consulting with our CCACs and other health care providers to determine how best to implement the 15 specific recommendations. We've already taken some steps—

Mr. Jeff Yurek: Are you going to come up with a target, or are you going to let CCACs have full rein to put money into bureaucracies as they see fit?

Hon. Eric Hoskins: That might be a decision that you would take. It's not a decision that I would take, of course—

Mr. Jeff Yurek: So you won't put any guidelines or metrics in place?

Hon. Eric Hoskins: Before you give me that kind of a binary question suggesting that I have to choose between one or the other—

Mr. Jeff Yurek: I'm just saying that you put in a target for CCACs across the province, saying, "Do not go above X% in your bureaucracy so that money is going to front-line care." What you're saying is the Wild West: "Do what you want." We've seen Champlain's CEO go up 72% in his own wages.

Hon. Eric Hoskins: That might be the history of your party; it's not the history of ours.

Mr. Jeff Yurek: Our party?

Hon. Eric Hoskins: You're putting words—

Mr. Jeff Yurek: You've been in power 12 years, Minister—

Hon. Eric Hoskins: You're trying to put words in my mouth, and I'm not prepared to accept that. You may choose the Wild West—

Mr. Jeff Yurek: I asked a plain question: Are you going to make a target for bureaucracy in the CCACs?

Hon. Eric Hoskins: With respect—

The Chair (Ms. Cheri DiNovo): One at a time, please.

Hon. Eric Hoskins: With respect, you may choose the Wild West, but I'm not—

Mr. Jeff Yurek: Are you going to make a target? Yes or no?

Hon. Eric Hoskins: I've indicated to the Auditor General and I've indicated publicly that we accept her report. We'll be implementing all 15 of her recommendations. Some of those recommendations pertain to efficiencies that we can find in the system—a system review. But I would hope that you would appreciate that, rather than jump into this immediately, we would take the time to review the report, to have the ministry analyze it, to review the recommendations, to consult with the sector—not just the CCACs but the entire sector—to actually find the best way to proceed to effectively implement those 15 recommendations.

Mr. Jeff Yurek: So it's okay that there is no target, no direction, from this ministry with regard to the bureaucracy. It's fair game.

Hon. Eric Hoskins: I think I've answered your question.

Mr. Jeff Yurek: I don't think you have.

Hon. Eric Hoskins: I think you want me to answer it in a way that I'm not prepared to because, as I mentioned, we're endorsing and implementing every single one of her recommendations—part of that includes finding further efficiencies. My responsibility as health minister is to make sure that we invest every single dollar that we receive so that it is most effective in improving patient care.

There's no question—and the Auditor General points to this—that substantial improvements can be made in the area of home and community care, specifically in reference to our CCACs. We're embarking upon that. As a result of Gail Donner's report earlier this year, we implemented a 10-point action plan to begin to find those efficiencies, to be able to make sure that we're maximizing the dollars that go to patient care. That's my obligation and my responsibility, and I take it very seriously.

The Auditor General's report that came out at the end of the summer: The ministry is doing their due diligence to make sure that we are implementing, in a responsible fashion and in partnership with the health care sector—we have a work plan to effectively implement all 15 of her recommendations.

Mr. Jeff Yurek: So it is your responsibility to ensure that dollars reach patient health care, as Minister of Health. Would you say, then, that the previous health minister failed in allowing 40% of dollars to go to the bureaucracy in CCACs?

Hon. Eric Hoskins: I would say that I take my responsibility very seriously. The Auditor General has provided us—alongside Gail Donner's report from the Expert Group on Home and Community Care—with very good advice, and I intend to take that advice very seriously and implement all of her recommendations.

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We have made it clear that home and community care is a priority for this government. We're investing roughly $250 million a year more for each of the next three years. It's roughly a 5% increase. We've increased dramatically home and community care since we came into office in 2003. So we'll continue to do that. We'll continue to make those improvements.

Mr. Jeff Yurek: Thank you.

The Chair (Ms. Cheri DiNovo): We now move to the third party: Madame Gélinas.

M^me^ France Gélinas: I just wanted to close on my health unit questions just to make sure that I will get what I want.

We all know that a wealthier neighbourhood is a healthier neighbourhood. The relationship between money and health, everybody knows it's there. We now have a new funding formula that shows that 80% of health units in the province are overfunded. This number,

by itself, to me, puts in question the validity of the new funding formula. How could 80% of our health units be overfunded? I cannot wrap my head around that.

But not only that, I've asked for the list that I will hopefully get from your ministry—the list has been shared with me informally already, but I want to make sure that I get the one from you guys. It's becoming clearer and clearer that if you are a small health unit, if you are in a rural or a northern area, you are the one who is being red-circled and you are the one who is going to have a flatlined budget till you catch up, which leads me to believe that the money is going to big, urban centres where you find the healthy population and the wealthy population. How certain are you that you got this new funding formula right to meet the public health needs of the people of Ontario who live in the north, who live in small catchments area of health units or who live in northern or rural Ontario? How robust is this?

Hon. Eric Hoskins: The formula which—believe me, and I think Roselle, to my left, can attest to the fact that it took many, many years for it to be developed. In fact, I think the most recent iteration—am I right that the process was chaired by our interim Chief Medical Officer of Health—

Ms. Roselle Martino: Yes.

Hon. Eric Hoskins: —and with wide engagement from public health officials and front-line public health workers as well. There are variables in there. For example, there's a specific variable to accommodate the unique challenges faced by our aboriginal population. There are other variables inclusive that recognize the unique challenges that, for example, our north and remote areas might face. This is a formula in which a tremendous amount of effort was invested to ensure that we get it as right as possible, and it's a formula that the public health community supports as well.

M^me^ France Gélinas: They do not. You're getting the same letters that I'm getting. I have Porcupine, I have—

Hon. Eric Hoskins: But that process, which was many years, and that support did not extend to the point in time where specific public health units became aware of the impact of that formula. So the formula is supported—

M^me^ France Gélinas: But that's not my question, Minister. My question is, do you believe that 80% of our health units are overfunded?

Hon. Eric Hoskins: But it's not a matter of overfunding. The formula, which is evidence-based with the sorts of variables in mind that I gave reference to—that that has indicated very strongly and very clearly to us that there are a number of public health units which are underfunded. If you make your funding determination based on public health need, it identified that there are a number of units that need to benefit from those incremental resources, and that's what we've done.

M^me^ France Gélinas: I agree with you that some of them are underfunded, but I don't believe that 80% of them should be red-circled and have a flatlined budget. They are not overfunded, but I'll put health units aside for now.

Hon. Eric Hoskins: If you'll allow me, it was my decision to limit the impact of the formula this year to the incremental portion, the 2% increase that we allocated to the public health envelope. So we've mitigated any potential negative effect on any public health unit.

All public health unit funding is being kept whole compared, to last year, on a calendar year basis. It was just that 2% increase based on a formula that was developed by the ministry in concert and collaboration with the public health sector itself, the process led by a public health physician, who later became the interim medical officer of health—a formula that I have much more confidence in than what historically, for a number of years, has simply been without thought, one could argue: an incremental increase given across the board to every public health unit without any reference at all to need.

M^me^ France Gélinas: Well, 80% of our public health units are not overfunded, and they're being red-circled right now and seeing no increase. I don't think we got it right, but I need to move on because I'm conscious of the time.

You gave me this piece of paper, the 2015-16 infrastructure investments in hospitals. You gave that to me last week—much appreciated. It's a list of 32 major hospital projects and planning under construction. I would like a few more columns to be added to this page. The first one is estimated completion dates; I'll go in alphabetical order. It says Atikokan General Hospital phase 1 redevelopment project: under construction. What are the expected completion dates, and what is the expected budgeted amount for each of those projects? Is this information that I can find someplace, or is this information you could give me?

Hon. Eric Hoskins: I will consult with the ministry to see if that information can be made available to you.

M^me^ France Gélinas: Very good. All right.

The last time I was in estimates, I spent a whole lot of time—it was back in 2012-13, and I don't know how come we didn't have them for a couple of years, but here we are.

We are moving hospital funding to HBAM, as well as to quality-based procedures. When it was first introduced—it says that we expect the base budget for hospitals to account for about 30%, HBAM to account for 40% and QBP to account for about 30%. Do we know where we are at right now? Are we meeting those targets? Are we there yet?

Hon. Eric Hoskins: I'm sure we do know where we're at. I am speaking slowly, imagining that some support may be provided—

Interjections.

M^me^ France Gélinas: It's pretty active behind you.

Hon. Eric Hoskins: —or, if it isn't being provided momentarily, it's something—do we have it?

Interjection: Yes.

Hon. Eric Hoskins: Even better. My deputy to my right has the answer.

Dr. Bob Bell: Ms. Gélinas, you described it appropriately. The health system funding reform anticipates that

we will have roughly 40% of hospital funding based on the health-based allocation method. Now, 37% of the entire hospital funding is based on the health-based allocation method. It also anticipates that we're moving towards quality-based procedure funding for a further 30% to account for 70% of the hospital's entire funding within the health system funding reform model.

Currently, this year we're anticipating that 13% of hospital funding will be based on quality-based procedures—these have been introduced—procedures such as hip and knee surgery, congestive heart failure, chronic obstructive pulmonary disease, cataract surgery—a number of different interventions. Surgical procedures have had best practices developed by expert panelists who outline best practice, and from that we estimate what the costing should be. Another big example is stroke care.

I can tell you, travelling around the province, the impact of quality-based procedure funding has been dramatic in that we have not only groups of experts working with Health Quality Ontario in developing these plans, we also have groups of physicians and nurses sitting around hospital planning tables across the province, looking to see whether or not their routine practices match up to the excellence of the procedures suggested in the quality-based program best practices.

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We're moving this forward. It's currently at 13%, as mentioned, heading toward 30% in the next year. We have a number of cancer surgeries—breast cancer surgery, colorectal cancer surgery—currently with the best practices being developed that will allow us to adapt further procedures to the quality-based funding mechanism.

M^me^ France Gélinas: Could I have a list of the quality-based procedures and the amount of money attached to each of them that are presently making the 13% you shared with me, as well as the list of—

Dr. Bob Bell: Future?

M^me^ France Gélinas: Yes.

Dr. Bob Bell: Yes.

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

That's for the 90 hospitals that are covered. For the 55 that are considered rural and northern, can I have the breakdown as to what their funding is made up of—what is their funding?

Hon. Eric Hoskins: I'll obviously take your request to the ministry. We'll consult to see if that is information that we can provide you.

M^me^ France Gélinas: Okay.

It used to be that in the funding schedule of the hospital accountability agreement, it used to be posted on the LHINs website so that people like me could go and see this. Now the LHINs don't do that anymore, and when I ask, they say, "You have to go to the website of the individual hospital"; that it's the hospital that will share the schedule of their funding agreement. Some hospitals do this very well; some hospitals don't at all.

What should be happening here, and how come this information used to be available and now it's really hard to get that info?

Hon. Eric Hoskins: The deputy might have a perspective on this or not, but I think you raise a really important question. I wasn't aware that this was part of the practice in the past. Obviously, the consistency with which this information is provided at the level of the individual hospital is important. It's something that we'll look into.

M^me^ France Gélinas: Okay, but is the practice that the LHINs make the accountability agreement available, or that the individual hospital does?

Hon. Eric Hoskins: Anybody know?

Dr. Bob Bell: My understanding is that it's the individual hospitals, simply because they have better understanding of the various impacts that has. But we'll follow up with that.

Hon. Eric Hoskins: Even that being said, there is no reason why we can't make it easy for the public to access that information. So even if it's at the level of the individual hospital, I think what I'm hearing from you is that we perhaps could do a better job to make that information easily accessible.

M^me^ France Gélinas: Correct.

Just before I go away from HBAM and QBP funding and all of this, when HBAM was introduced in 2012, the government said that 60% of hospitals would see an increase in funding under this model. Since 2012, how many of those 90 hospitals actually saw an increase and how many saw a decrease in funding?

Hon. Eric Hoskins: Please, if you have the answer, go ahead.

Dr. Bob Bell: I don't have exactly that answer; we'll pull that answer together.

The HBAM portion of health system funding reform has been consistent with a $5.1-billion base that has been evaluated every year. The additions to that funding have been related to the post-construction kinds of operating budgets that we add to hospitals on a regular basis. As new capital projects are brought into the service of patients, they are supported by the operating budgets for those hospitals. But the actual HBAM allocation has remained consistent. How many hospitals have increased their HBAM allocations and how many of them have decreased their allocations: The actual sum of money has stayed constant. The proportion of hospitals that have increased from year to year changes, of course. Each year there will be variability in the number of hospitals.

If I'm understanding, you'd like to know in the past year how many have increased and how many have decreased. Is that a reasonable—

M^me^ France Gélinas: Yes, you understood my question. I go from a statement. The government—the Ministry of Health, the minister at the time—made a statement that 60% of hospitals would see an increase in funding through HBAM. So—

The Chair (Ms. Cheri DiNovo): I'm afraid we are at the 10:15 mark. We will pick this up later as we recess until this afternoon at 3:45.

The committee recessed from 1015 to 1554.

The Chair (Ms. Cheri DiNovo): Good afternoon, members. We will now resume consideration of vote 1401 of the 2015-16 estimates of the Ministry of Health and Long-Term Care. When we recessed this morning, the third party had five minutes and 32 seconds left in their rotation. Madame Gélinas, please proceed.

M^me^ France Gélinas: All right. We were talking about hospitals, and I will continue with a few questions.

When I reviewed some of the questions I asked you this morning, I'm not sure I got a full answer. Remember I was talking about HBAM and QBP and global budget?

Hon. Eric Hoskins: Yes.

M^me^ France Gélinas: I just wanted to make sure that when you agreed to give me that information, it will be broken down by 90 hospitals, I think it is, that presently get funded that way. You've given it to me province-wide, but I want it hospital by hospital.

Hon. Eric Hoskins: By individual hospital? Okay. I hope I mentioned this morning that I'd be happy to speak with the ministry about your request.

M^me^ France Gélinas: So if it's feasible, it will come?

Hon. Eric Hoskins: I will certainly review that with the ministry, just to follow up on your request.

M^me^ France Gélinas: Thank you. I think one of the last questions that I had asked was, remember that in 2012, the government said that 60% of hospitals would see increased funding under the new HBAM funding model. I will have a list of hospitals that saw an increase since 2012, and a list of hospitals that didn't?

Hon. Eric Hoskins: The deputy and I were just talking about that as well. We're not familiar with the time period that that 60% referenced, whether it was for the current or perhaps the next year, or over a period of time. Given a certain amount of ambiguity, at least on our side, with respect to that specific statement that was made, I've asked the ministry to examine it in the context of the request that you've made. Unless you have that clarity, we need to examine what time period or point in time it was actually referring to.

M^me^ France Gélinas: Okay, I'll make it simpler. This is something that was introduced in 2012. If we look at 2012-13, 2013-14 and 2014-15, you can give it to me as a chart over time as to what the funding is for hospitals that are within those 90 hospitals that receive HBAM funding.

Hon. Eric Hoskins: Perfect. Thank you for that clarity. I think the ministry no doubt has taken note of that and will examine your request.

Dr. Bob Bell: If I could perhaps expand just a little bit on that. Part of the difficulty we have, Ms. Gélinas, is that year by year, HBAM has changed in that there were mitigation corridors put around HBAM. As you know, this is the fourth year that the health-based allocation method has been used. It's the first year that there's no formal mitigation.

If we look at year 1, hospitals that had more than 2% negative variance could not lose more than 1% or 2%. Hospitals that had efficiency variance or population growth variance greater than an upper mitigation corridor couldn't gain more than that.

That's part of the reason why we were sure, in the early days, that more hospitals would win than lose. That was true through the first three years. There were mitigations, especially on the bottom end, of the HBAM results, the efficiency results, the population growth results that hospitals served.

This is the first year that all mitigation has been removed, so if you're quite inefficient with respect to your actual versus expected costs per weighted case, there could be a substantial reduction in funding, but not so much if you look over the four years, because hospitals have had the opportunity to improve.

We're still, of course, providing mitigation funding to hospitals that have difficulties, but no longer in a formal way where we calculate the mitigation and apply that immediately; now it's on a case-by-case basis. Anticipating hospital and improvement plans to improve efficiency are part of the plan that will allow us to provide mitigation.

M^me^ France Gélinas: Yes. I will leave it up to you to give me as much detail as you want. But at the end of the day, if I just get the amount—whether it's the amount because it was within the 2% or not—the actual amount that was transferred, I will be happy with that. If you want to add information as to how it was calculated, I will be even happier.

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Hon. Eric Hoskins: Okay.

M^me^ France Gélinas: Sounds good?

This year, the ministry made a $7-million announcement for small hospitals. Fifty-six of them were notified that their base funding would be increased, but there are 78 hospitals with fewer than 100 beds. When you use the term "small hospital," do you always mean the 56—which I thought were 55—or the 78—

The Chair (Ms. Cheri DiNovo): I'm afraid we're going to have to wait for the answer to that, because your time is now up.

M^me^ France Gélinas: The suspense will be—

Hon. Eric Hoskins: We'll come back to that.

The Chair (Ms. Cheri DiNovo): We will move to the government side: Mr. Ballard.

Mr. Chris Ballard: Thank you very much, Minister and Associate Minister, for your information so far today. As usual, during estimates, this is very enlightening, very educational. I always appreciate the opportunity to listen and to learn on a wide range of topics. It's an interesting committee to be sitting on.

My question is to you, Minister Damerla. Parents in Ontario expect that their children will enjoy every opportunity to grow up healthy and happy and ready to be successful in life, and they expect our government to work together with them to support their efforts to raise healthy families.

I know, as a parent of three now-adult children, I can look back on some of the struggles. I wish I hadn't been so concerned about certain things, looking back. Now,

seeing where my kids are, we're quite proud and happy about where they're at.

I think my children's generation was probably the first generation to have grown up with a computer and were expert computer users long before I was an expert computer user, and really have never known life without computers.

An interesting comment, as a bit of a sidebar—yesterday's report on the number of children, I believe, under the age of four who spend time using touchpad devices. It reminds me of a friend who was at the dentist's recently, watching a toddler trying to swipe the National Geographic to change the page and couldn't figure out—thankfully, her mother filled her in on this old technology called a magazine, and she was off and having a good time. I'm meandering a little bit along there.

As a parent, you're concerned about, is your child sitting too much? Are they in front of this computer too much? It used to be, when I was growing up, that my father would say if I watched any more TV, he would be able to see the CBC logo in my eyes.

We have these concerns about making sure our children are healthy, making sure our children are active. I know, when my children were in elementary school, one of the things that drove me absolutely crazy was the loss of physical education opportunities for them. Thankfully, that has come back. I see in our elementary schools now that there's lots of time for kids to be outside, running around, blowing off steam, getting some exercise, those kinds of things. I know parents today have these concerns. I worry that even the current generation, the current group of young children, don't even have the opportunities, we'll say, that my children had to be active, to be healthy.

I know that in doing some reading over the time—we can agree that Ontario's families deserve, really, nothing less than the best for their children. A statistic that I find really shocking comes from 2012, that almost one in every three children in Ontario had an unhealthy weight. I don't know; I don't seem to think that it was that bad when my children were that age. So, as a parent, I worry about, when I have grandkids, where they are going to be at. Are children spending too much time in front of the television, the computer, not being active enough, or whatever?

With that 2012 stat that one in every three children in Ontario had an unhealthy weight—the problem, we're told, is more severe in boys than girls. I've seen this firsthand from my work in Canada's Far North, particularly in aboriginal children.

I'm wondering what you can do to give us an update on what initiatives your ministry has taken to promote healthy weights in Ontario's children.

Hon. Dipika Damerla: Thank you for that excellent question. When I first heard the statistic that you just mentioned, that one in three Ontario children has an unhealthy weight, I was taken aback as well. Part of it is, as you've said, a generational shift. When I was growing up, my mother was mostly concerned with me eating more and more. It was all about, "Eat, eat, eat!" I guess it was because we were so active.

Mr. Chris Ballard: My mother had three boys, so it was, "When are you going to stop eating? We can't afford this."

Hon. Dipika Damerla: I hear you.

To turn that around and now move towards the idea of a healthy weight but from a different perspective is certainly a societal shift, and it's one that's taking place across many, many jurisdictions; Ontario is one of them. That's why, in 2013, our government created the Healthy Kids Panel, a panel of experts to recommend how the province could keep more kids at healthy weights.

The Healthy Kids Panel submitted its report, No Time to Wait: The Healthy Kids Strategy, to the then Minister of Health and Long-Term Care in March 2013. In response to the panel's recommendation, our government launched Ontario's Healthy Kids Strategy, which takes a whole-child approach to healthy child and youth growth and development.

The Healthy Kids Strategy is focused on three pillars. The first one we call a healthy start, which supports health before and during pregnancy to build a foundation for a healthy childhood and beyond. The thinking here is that if the focus on being healthy starts when the mother is carrying the child, when the mother is still pregnant—the evidence shows, for example, that breast-fed children tend to be of healthier weights than children who are not breast-fed. That's where the idea of the healthy start comes.

The other pillar that we have is healthy food, which is kind of self-explanatory. It's not just about how much we eat, but also about what we eat, and that healthy food lens.

Finally, we have healthy, active communities, which are initiatives like the Healthy Kids Community Challenge, which I look forward to talking about, which works to build healthy environments for kids in their communities.

If you'll indulge me, I'd like to drill down a little bit on these three strategies, which are healthy start, healthy food and healthy, active communities.

Mr. Chris Ballard: Please.

Hon. Dipika Damerla: The healthy start initiative is primarily focused on providing breastfeeding supports, including breastfeeding telephone supports, which, as of April 2014, provide 24/7 expert breastfeeding support for mothers and expectant mothers through Telehealth Ontario, which provides confidential breastfeeding support, advice and referrals from registered nurses with specialized breastfeeding training.

I really think that support is key. As a young mother, I still remember going to St. Michael's Hospital. Next to St. Michael's Hospital but attached to it, there was this wonderful doctor. I can't remember his name now, but when I was struggling and my baby was just weeks old, I went to him for some support around breastfeeding. I can tell you this, MPP Ballard: Without that support, I don't know if I would have continued to breastfeed.

Eventually, I wound up breastfeeding my child much, much longer than the recommended six months, but that initial support made a world of difference. So I am really invested in the idea of being able to provide new mothers with breastfeeding telephone supports.

Baby-Friendly Initiative Ontario, which is a collaboration with organizations such as the Health Nexus Best Start Resource Centre in Toronto East General Hospital, is leading the delivery of supports, resources and training to hospital and community-based health care organizations seeking the baby-friendly initiative designation, the globally recognized standard for infant feeding and breastfeeding promotion.

Again, the idea is that the vast majority of moms will have their babies in hospitals, so how can we make those first two or three days when a new mom who has just had a baby and is in that hospital—how can we make the environment in that hospital breastfeeding-friendly? That is really key. That is another piece to our healthy start.

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The final piece to our healthy start is the targeted breastfeeding supports, which our government is funding through the Health Nexus Best Start Resource Centre, to administer grants to community organizations to develop and implement new initiatives targeted for mothers in population groups that have lower rates of breastfeeding and/or who experience challenges accessing existing breastfeeding supports.

That takes care of pillar number one.

I'm moving on to the healthy foods pillar. I'd like to talk about a key initiative by which we can ensure our young people are getting the healthy foods they need, and that's the Student Nutrition Program. It's led by the Ministry of Children and Youth Services. The program provides nutritious meals to school-aged children and youth. During the 2013-14 school year, the program served more than 756,000 children and youth across 4,450 programs. That just gives you the breadth and width of this program.

Through the Healthy Kids Strategy, our government has also been able to increase support for the Student Nutrition Program by $3 million. As a result of this, approximately 250 programs in previously unserved schools were implemented during the 2013-14 school year.

Finally, I want to come to the active living piece. A big piece of that active living is a program which I am very excited about, and that is the Healthy Kids Community Challenge. We have selected 45 communities across Ontario, led by municipal governments. These are 45 municipalities across Ontario that are getting funding from the province of Ontario to lead locally designed and locally implemented strategies to help kids in that community lead a more active life and eat healthier. The key over here is, it's community-led. It was a competitive process. A number of municipalities and other groups applied for it. The groups that were successful, the communities that were successful, were the ones that had an application that was collaborative, that showed leadership by the municipality, but the municipality coming forward with a number of stakeholders and partners to lead this program.

I just wanted to give some idea of some of the communities that are going to be receiving this funding. I just wanted to share that, so if you will bear with me, with the modern technology that we were talking about—

Mr. Chris Ballard: You need a toddler to operate that. We need toddlers to operate this modern technology, I find.

Hon. Dipika Damerla: Yes. Apparently, I'm going to rely on a more traditional one.

Mr. Chris Ballard: Oh, good—paper.

Hon. Dipika Damerla: It's a little bit easier.

The 45 communities—and I think, committee members, you will be very interested to learn of that—are the Misiway community health centre, an aboriginal health centre; Centre de santé communautaire CHIGAMIK Community Health Centre; Wabano Centre for Aboriginal Health Inc.; Noojmowin Teg Health Centre; De dwa da dehs nye>s Aboriginal Health Centre; Shkagamik-Kwe Health Centre; town of Collingwood; township of Uxbridge; town of Georgina; county of Hastings; city of Peterborough; city of Toronto; city of Burlington; town of Ajax; city of Oshawa; city of Sault Ste. Marie; city of Kenora; city of Temiskaming Shores; city of Greater Sudbury; city of Thunder Bay; town of Thessalon; regional municipality of Waterloo; city of Windsor; municipality of Lambton Shores; city of Hamilton; regional municipality of Niagara; city of London; city of St. Thomas; municipality of Grey Highlands; county of Huron; city of Guelph; city of Brantford; county of Middlesex; town of Aurora; county of Renfrew; city of Ottawa; the united counties of Leeds and Grenville; city of Kingston; township of Alfred and—Deputy, can you help me with that?

Dr. Bob Bell: And Plantagenet.

Hon. Dipika Damerla: —and Plantagenet—thank you; municipality of Chatham-Kent; town of Marathon; and the town of Kapuskasing. That's 42, so there should be three others—oh, the city of Toronto accounts for four communities. I think we have covered the entire province.

What's really exciting about this is it includes the aboriginal communities. I've had the opportunity to go to a number of these communities, and I can tell you, MPP Ballard, that the communities that have received this funding are so excited about this. When I was in Hamilton, I was at the De dwa na dehs nye>s Aboriginal Health Centre, and they couldn't talk enough about how they needed this funding to really provide tailored, culturally appropriate programs for aboriginal children in that area. They talked about how it's moving from that one-size-fits-all approach to saying, "What are the cultural needs of the community?" and "What would resonate with the community?" when you want to create an environment that's healthier for the children of that community. It was so nice to see the passion—and they felt recognized. They felt really acknowledged that—

The Chair (Ms. Cheri DiNovo): Mr. Ballard, I'll let you know that you have just under five minutes left.

Hon. Dipika Damerla: Thank you. I had a similar experience when I was in Windsor.

In every town that I went to for the announcement, without fail, the mayors were there, and we know how busy they are. This was because this was so important to every single community.

I'm really looking forward to the rolling out of this particular program, and I think it certainly is a key piece of the Healthy Kids Strategy. But MPP Ballard, as you know, we're not stopping here. We have the minister's working group, and you're a part of that, so you're aware of the fact that we continue to look at what else is out there that we can do to help tackle this issue and ensure that Ontario's kids are of a healthy weight.

Mr. Chris Ballard: Very good. Before our time wraps up, I just wanted to thank the ministry. As you mentioned, Aurora is one of the towns in my riding of Newmarket–Aurora that has received funding and assistance through the Healthy Kids Community Challenge in partnership with a fantastic environmental organization called Windfall Ecology. So I'm really looking forward—they haven't told me all of their exciting things that they've got planned, but I have a feeling that between the town of Aurora and Windfall, they're going to have some really great ecology-based activities for young people today. I know they were so thrilled—the mayor, members of Windfall Ecology, councillors, members of the community—to see us coming forward and recognizing their good ideas instead of, as you said, that top-down.

It appears to me that your ministry has done a fantastic job of covering all regions of Ontario, especially reaching out to aboriginal communities, both urban and rural, and of course northern.

Perhaps I'll put a shameless plug in. I'm told that sometime in February, we're supposed to have our launch. I'll have to put a phone call in to your office to see if we can get the appropriate associate minister to attend the rollout there.

Hon. Dipika Damerla: I'd be delighted.

Mr. Chris Ballard: If I can just segue for a second, I'm so glad to hear you talk, too, about the emphasis on aboriginal communities. I've spent many years working in the Far North of Canada, hearing things about exceptionally high type 2 diabetes rates—absolutely off the scale—and looking at the work that communities are doing in the north to return people to more traditional foods and more on the land-based activities to try to pull away from the high-fat, high-salt, high-sugar diets that too many of us indulge in, and seeing some real success with that.

I know that what your ministry is focusing on will also help those children, our future adults, get a handle on the mentality about being healthy now. If we can get them while they're young—this is for everybody—we know that, as we age, we'll have better habits and a much healthier life.

Hon. Dipika Damerla: The one other program that I think is worth mentioning—and I spoke about it last time at estimates briefly—is of course our new legislation that's going to make it mandatory for any chain restaurant that has more than 20 locations across Ontario to post calories.

Again, this actually came out of the Healthy Kids Strategy report, No Time to Wait. The idea was that kids don't eat healthy in isolation. They eat healthy when parents eat healthy. So the idea of putting those calories up in restaurants is—really the whole idea that families that eat healthy, children eat healthy.

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I'm really excited. We are moving closer and closer to implementation. The legislation has been passed. We're working on the regulations, consulting with industry to get it just right, but I can tell you that I am really excited about what that's going to mean in terms of healthy weights for Ontario's kids, but, I think, healthy weights generally for all Ontarians.

The Chair (Ms. Cheri DiNovo): I'm afraid that your time is up, Mr. Ballard.

We'll now move to the official opposition, Mr. Smith.

Mr. Todd Smith: I just submitted some questions to the minister and, hopefully, Minister, you can get back to me with the answers because I know some of the members here want to ask you questions about some other issues as well.

But in my riding, Quinte Healthcare operates four hospitals: Belleville, Prince Edward county, Bancroft and Trenton. Specifically, these questions come from our TMH group, which is the grassroots community group, and you're familiar with the efforts I'm sure that they've been undertaking to make sure that they keep Trenton Memorial Hospital viable and operating into the future. I know that the member for Northumberland–Quinte West, your colleague Mr. Rinaldi, has been speaking with you about this as well, but I did want to just pass along these questions and, if I could, read them into the record, and if you had a brief response to them, maybe we could get back a more fulsome answer in the future.

So this comes from John Smylie, who's been very active on the health care front in the Quinte West and Trenton area: "Why does the funding formula penalize rural multi-site hospitals such as Quinte Healthcare?

"Is regionalization of health care being forced on hospital corporations because of inadequate funding, resulting in hospitals such as TMH being stripped of services?

"Why is the ratio of administrators to patients in Ontario health care so high?

"Is the Minister of Health going to enact the recommendations put forth from the Quinte West–Brighton community task force?"—which was chaired by Glenn Rainbird.

The last question: "Will he place a moratorium on the funding cuts to Quinte Healthcare and Trenton Memorial Hospital until the above task force recommendations are implemented?"

That's again from John Smylie, who's chair of our TMH. So if you had a few brief comments, that would be great.

Hon. Eric Hoskins: Sure. So I'll just start, but feel free—I'm sure you will—to tell me when you'd like to move on to other questions as well. This is obviously an important issue.

We've had conversations about this in the past. In fact, it was one of our conversations that led Prince Edward county to be designated—it hadn't been to that point in time, but we reviewed it and designated it as a small and rural hospital, which through the corporation enabled it to become eligible for the small and rural hospital funding envelope, which is $20 million per annum.

As you've referenced, it's a corporation of four hospitals that is undergoing some change now. I think it's fair to say that this is one of my top priorities in terms of hospitals. I've been very engaged in this issue. You referenced our colleague Lou Rinaldi as well—that both of you have been strong advocates for this.

So when the corporation was projecting last year that it would be in a deficit position, we stepped forward with some mitigation funding for it. I think it was in the order of $3.5 million that resulted last year, in fact, in the corporation being in balance. But most importantly, which I think is the issue that you're referencing, the corporation's looking forward to remaining in balance and providing the services that people deserve in that area. I think it's a population of about 160,000 people served by the four hospitals.

I became concerned—well, it's not that I became concerned; I was compelled to ensure that the community was being adequately consulted on any consideration being made by the hospital, that the LHIN was maximally engaged as well, which they are. As a result of that, an advisory committee or group was established, under the leadership of Glenn Rainbird, who I understand is a respected community member, that has resulted in the recommendations of the report that you referenced.

So, for me, it was important to make sure that there's a strong level of community engagement. We've now received the report. It has been reflected back to the community—it's a public report, of course—and it's being considered by the board of Quinte Health Care. But it's important to state that no decision has been made as of yet in terms of pursuing any or all of those recommendations.

I think the way I've looked at QHC and the population served is that it's very—I'm not dragging out my answer, by any means, but it's important to state that I grew up in a small town with a small hospital, and I understand how vitally important those services and that hospital are, for a whole variety of reasons, including being an economic driver and employer and the like.

I want to make sure that we've exhausted every possibility to make sure that we do attain that goal of sustainability, but we do it in a way which provides the services that people depend on. That's why I've been prepared to move a little bit more slowly, I think, as I would hope you would agree, to get that community input and really look at all opportunities. That's how I've been pursuing this.

Mr. Todd Smith: Okay. I appreciate that. Again, they're in the process right now of removing $11.5 million from their budget, so it's causing a lot of tense moments in the community.

We'll leave it at that for now because I know Mr. Harris has some questions.

Hon. Eric Hoskins: Will you allow me just a very brief supplement?

Mr. Todd Smith: Sure.

Hon. Eric Hoskins: I know that last year, they were anticipating a deficit in the order of $5 million in excess. At the end of the day, we were able to work with them, so they ended up with a small surplus. So I would want to reassure the community that we're working very closely with the hospital so that it can not only be sustainable from a fiscal perspective, but it can do that in a way which I think the community can have confidence in the services delivered.

Mr. Todd Smith: Thank you.

Dr. Bob Bell: If I could just add that one really important element of your question was why create these regional health networks? A great example comes from Quinte. About four years ago, Quinte was having a great deal of difficulty with sterilizing its instruments for surgery adequately. They've reinvested in Belleville, as you know, in a new central sterilization facility. It wouldn't be cost-effective, it wouldn't be rational, to have that kind of a high-cost, high-effectiveness facility in two different hospitals, so certainly focusing most surgery in Belleville, from a quality perspective, makes huge sense.

I know they're looking at focusing on ophthalmology services in Trenton, which also makes sense. It doesn't require that kind of detailed sterilization. So that's an example of how regionalization improves quality of care for patients.

Mr. Michael Harris: Great. Minister, good afternoon. Deputy, Associate Minister and staff, welcome. Minister, I'm going to spend some time, obviously, on a rare disease in this round. Clearly, it's something that a lot of Ontarians are unfortunately living with. There are several treatments, whether they be surgical or pharmaceutical, that are not covered under OHIP or through their private insurance. You know that we've had several patient groups come through to Queen's Park. I will say, right off the bat, that I want to thank you for, last week, spending some time with a couple of girls who came in, suffering from EDS. I witnessed your conversation with them. There's no doubt that you've heard what they had to say. I think that they came away feeling optimistic from what you had said, and I want to thank you for that. There's no doubt that you have an immaculate amount of care for these folks. But I think it's fair to say as well that a lot of these patient groups have been let down by the system throughout the years. There are some cracks, loopholes, what have you, and that's where I'm going to focus a bit of my time today. So I wanted to get that out, first off.

With regard to PKU, you'll recall a bunch of patients coming through. Last May, they were here, actually, and that day you had promised to review the criteria for one drug that would allow them to live a normal life. It's called Kuvan, I believe.

Hon. Eric Hoskins: Yes.

Mr. Michael Harris: I'm just wondering if you can tell us how that review has gone—if you can tell us when it began and if it's still ongoing or if it has been completed.

Hon. Eric Hoskins: Thank you for that question and thank you for your earlier comments as well. The commitment that I made to those young women that are suffering from EDS was a very serious commitment. I appreciated the time they gave me. I'm hopeful that I'm just—my staff now are working on following through on the commitment for them to be able to present their stories to the working group that was established on EDS in my ministry and to tell those stories in my presence as well. I think that that patient's story sounds like—it's much more than a story, but their experience with the health care system and the challenges that they're facing with their illness—it's very important that the working group hear from them directly. So I committed to doing that.

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With regard to PKU—phenylketonuria—it's one of those diseases that's not widely known unless you or somebody you know suffers from it. It can be devastating; it can be fatal if it's not treated appropriately. The main form of treatment to date has been dietary, but there is one drug that has been approved, as you've referenced: Kuvan, which has been approved by Health Canada as in fact the only drug approved for the treatment of phenylketonuria or PKU.

I think, as you and Ontarians can appreciate, we've taken the politics out of decision-making with regard to approving new drugs. We have an expert committee and officials in the ministry who make decisions based on science and evidence that the drug in question is effective for the criteria that it's prescribed for. The approach to Kuvan has been no different than that. In fact, when it was considered by a national body, the national Common Drug Review, in 2011, it was actually the determination of the review members at that point that it not be listed in Canada by provincial or territorial drug programs.

Mr. Michael Harris: Minister, I don't want to be rude—

Hon. Eric Hoskins: Please.

Mr. Michael Harris: —but we only have probably 12 minutes in this round. I want to specifically know—and if you can't answer, you can get back to me, perhaps, but you did commit in May to reviewing or you'd ask your ministry to review those clinical criteria again. I'm asking: What has been done since May pertaining to that review you'd asked your ministry to undertake, specifically to this?

Hon. Eric Hoskins: I followed through on that commitment. It's sometimes difficult to know how much information you want, so I appreciate your asking me to provide that clarity—

Mr. Michael Harris: No, I'll—

Hon. Eric Hoskins: I know you're going to do it.

Mr. Michael Harris: I don't want to be rude about it, but I've got to keep going.

Hon. Eric Hoskins: You only have so much time; I get that.

I made that commitment and I followed through on that commitment. In June of this year, BioMarin informed the ministry, and we had ongoing discussions that they intend to—have they filed their submission?

Interjection.

Hon. Eric Hoskins: They had informed us that they intend to file a resubmission to the Common Drug Review for Kuvan for the treatment of PKU. As my officials are indicating, that resubmission is expected, because it really is at this point up to the manufacturer; they're required to resubmit. They've indicated that they are likely to do that before the end of this calendar year. As with the pan-Canadian Pharmaceutical Alliance, that is the process that we follow. Hopefully we'll have a pan-Canadian approach, but the Common Drug Review will review that resubmission.

Mr. Michael Harris: So you expect everything to be submitted by the end of the year and, then, where do we go from here, after that?

Hon. Eric Hoskins: Bob, go ahead.

Dr. Bob Bell: Part of the issue here is to determine which patients with PKU are well-controlled by diet and which patients may benefit from actually getting access to the BioMarin drug. Currently, there's no good evidence of who would benefit that's predictive. You'd have to put all patients on the drug, many of whom wouldn't need it.

The company is apparently developing evidence of the genotypes, I understand, that will actually be predictive in suggesting which patients would get better outcomes. That's the data that we're expecting to see. Then we would go through the usual utility measurement of how much benefit that would mean for the patients and—

Mr. Michael Harris: Have there been any changes to the criteria since, perhaps, May that would allow more patients to access Kuvan? And I guess a follow-up that—

Interjection.

Mr. Michael Harris: So no? None of the criteria has been changed since May.

I'm wondering if you can tell the committee—or you can probably get back to us on this—how many patients have applied and how many have met the qualifications for Kuvan to have the drug paid for by the province of Ontario. I don't expect you to have the answer, but if you have it, great.

Dr. Bob Bell: There was one application in February 2013 that was incomplete; the application was never completed. To this year, 2015, there have been three applications to date that have not been approved based on existing criteria.

Mr. Michael Harris: There are no potential changes coming up to the criteria at all?

Hon. Eric Hoskins: Potentially, as a result of the Common Drug Review process. So we welcome the application, the resubmission—

Mr. Michael Harris: Right, and you expect perhaps early in the new year—

Hon. Eric Hoskins: Is there an average time that the CDR takes to review an application?

Interjection.

Hon. Eric Hoskins: Come on up.

Mr. Michael Harris: Yes, because you probably will have a few other questions asked of you as well. Just state your name, so I know.

Dr. Bob Bell: Suzanne McGurn is our executive officer of the publicly funded—

Mr. Michael Harris: Okay. Good afternoon, Suzanne.

Ms. Suzanne McGurn: Once the material is completed, it will go through a process at CDR. Depending on the number of products in the queue—they are moving through quickly—it would be expected that it would be assessed in three to six months. After that period, the provinces would then, based on the recommendation, make a determination of whether there were to be pan-Canadian negotiations or any further action on the file based on the recommendation.

Mr. Michael Harris: I just want to reinforce the commitment you had made again in May, as per Hansard, that you would direct the ministry to review the criteria etc. I hope that you will follow through on that commitment you made, particularly for those folks.

Obviously, aHUS is another significant patient group that has come through. Again, they were here in February about interim funding for Soliris to patients with the syndrome who met the defined clinical criteria of the disease. How do patients access that interim funding?

Hon. Eric Hoskins: How do patients access the interim consideration for the drug?

Mr. Michael Harris: That's correct, yes.

Hon. Eric Hoskins: Maybe I'll let Suzanne answer that again in a second. Specifically the use of Soliris for aHUS, which is what you're referring to, which is part of the pan-Canadian process as well, but notwithstanding that: Again, I want to emphasize that this was a decision that was made by the ministry in consultation with stakeholders, patients, patient advocates and clinical experts as well. The ministry felt compelled or confident to, on an interim basis, make this drug available for certain criteria for aHUS patients—

Mr. Michael Harris: How many patients were actually given that?

Hon. Eric Hoskins: Ten, I think—

Ms. Suzanne McGurn: I will confirm the number for that, but it is not more than 10 individuals. With regard to your opening question about what the process is, the interim criteria are posted and available to the clinicians. As well, we have a good dialogue with the clinicians that treat this type of illness, and there is a process for them to apply.

Additionally, there are a handful of applications that were received at the time that have four criteria that were not part of our interim criteria but were included in the recommendation that was provided by the Common Drug Review. So we are holding on to those applications as well at this time while the process continues.

Hon. Eric Hoskins: Four of them.

Mr. Michael Harris: So you'll connect with those folks and get them to—I know we're getting close to time here, but EDS is the next one. We recently met with a bunch of those folks. Clearly, many Ontarians suffer from EDS. They saw the two girls come through, and you committed to a working group.

I'm just wondering if you can tell me who is on that working group. Has it met? How frequently will it meet and when will it report back?

Hon. Eric Hoskins: My deputy can tell you who is on the working group. It has met. Thank you for arranging not only the visit to Queen's Park of these courageous young women, but also the opportunity that I had to meet with them. I told them about the work that was under way, largely as a result of the challenges that they were facing.

There are two aspects. One is the working group, to look specifically at EDS in this province with the goal of providing Ontarians like these young women the confidence that they can get the support and service in the health care sector in this province that they deserve, or if they can't get it here, they can avail themselves of it outside of the province.

Also, with SickKids and Critical Care Services Ontario and others, a working group, I think we're calling it, or it may be an expert panel, which is looking at pediatric surgeries as well, but most particularly looking at the rare diseases that may require surgical intervention to see how we can provide better support to them. Also, if there is a question, for example, of obtaining services or surgery or procedures outside of the province because they're not here, this expert panel can help provide us with advice, hopefully in an expeditious fashion so that we can respond to those requests in a more timely fashion.

In terms of the membership of the working group itself—

Dr. Bob Bell: Yes. The expert panel has met three times already. It's chaired by the chairman of surgery at the University of Toronto, who's an internationally renowned pediatric neurosurgeon, Dr. James Rutka, and co-chaired by Karen Kinnear, vice-president of SickKids.

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The complexity of treating Ehlers-Danlos disease is represented by the membership of the panel since there's a multiplicity of problems that need to be managed. There's an expert anesthetist; there's an expert in clinical metabolic genomics from the University Health Network; there's an adult neurosurgeon since EDS patients, of course, who go from the pediatric age group to the adult often have occipital-cervical spine problems; Dr. Michael Fehlings is an international expert at treating occipital-cervical spine problems—lots of experience in EDS; Dr. Allan Gordon, who is a pain specialist and neurologist at Mount Sinai Hospital; Dr. Juan Guzman, who's an expert

at the internal medicine problems that EDS patients have; Dr. Andrew Howard, pediatric orthopedic chair at SickKids Hospital; as well as staff from Critical Care Services Ontario—

The Chair (Ms. Cheri DiNovo): I'm afraid you're going to have to submit that. You are out of time, Mr. Harris.

We will move on to the third party: Madame Gélinas.

M^me^ France Gélinas: I will repeat the question that had to do with small and rural hospitals. So $7 million got rolled out to 56 hospitals—anyway, 56 hospitals were notified that their base funding would be increased through the $7 million. Where is the cut-off for "small hospital"?

Hon. Eric Hoskins: If you'd bear with me just a second, I've got the answer.

Dr. Bob Bell: Do you want me to start off?

Hon. Eric Hoskins: Go ahead.

Dr. Bob Bell: There are two elements here. A small hospital is determined not by the number of beds but by the number of weighted cases that are treated in the hospital within a year. That cut-off point is 2,700 weighted cases. There's also an eligibility criteria for rural hospitals. Small and rural hospitals are eligible for a $20-million fund that encourages innovation in service provision—the development of hub-like services. Rural hospitals are defined as communities which are less than 30,000 people who are a greater-than-one-half-hour drive time at posted speeds from a community that has more than 30,000.

The small and rural hospitals are eligible, based on fewer than 2,700 weighted cases a year, for a 1% annual increase in their budget as opposed to being part of the health services funding reform component. Small and rural hospitals are also eligible for the $20-million fund that we've described.

M^me^ France Gélinas: All right. So the number would be 56, or it could vary because the 2,700 weighted cases would vary?

Hon. Eric Hoskins: It could very well vary, yes, but the number that I have, which I believe reflects 2014-15, is 56 small and other hospitals.

M^me^ France Gélinas: Okay. Very good.

Coming back to the Small and Rural Hospital Transformation Fund, I'm fully aware of this fund, as it came during the minority government. I would be interested in knowing—when you did the commitment at the time, it was for a three-year commitment, and that was in the 2013-14 Ontario budget. Is this something that will continue or is this something that will end, and when will it end?

Hon. Eric Hoskins: This $20-million fund: This is the third year of the fund, as it was initially expected to be. As we move forward in the coming months in ministry negotiations leading towards the budget, obviously the possible extension of this fund would be one of the considerations that we bring forward to the budget consultations.

M^me^ France Gélinas: So we'll know in the next budget if it's there or not?

Hon. Eric Hoskins: Yes.

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

The other question that I wanted to ask is that the last stats that I got for the number of beds came from 2012-13. In 2013, when I was in estimates, I asked what the total number of acute care beds was. The answer was 18,585. At the time, we had 4,813 that were mental health, 5,547 chronic care, 2,485 rehab, 2,100 bassinet—you get the idea. Can I have the same breakdown of beds for the missing years?

Hon. Eric Hoskins: It's read into the record. Certainly my ministry, if they haven't taken a note already, will take a note from that.

M^me^ France Gélinas: Okay. Last time, you had given it to the committee for the province. Is it feasible to have it per LHIN?

Hon. Eric Hoskins: I don't see why not, so that's something, as well, that I'll certainly ask the ministry to look into.

M^me^ France Gélinas: Okay; much appreciated. While we're talking about hospitals—hospital parking fees: You had made a commitment to address hospital parking fees. I know that you've been collecting data. In the data that you've collected, do we know much money is collected per year through hospital parking fees, and what is this amount?

Hon. Eric Hoskins: Yes, we do. You're right; we made a commitment to address the cost of hospital parking in the province. In 2014-15, 61% of our hospitals reported parking revenue. The total reported parking revenue was $172 million.

M^me^ France Gélinas: Seventy-two million?

Hon. Eric Hoskins: One hundred and seventy-two million dollars.

M^me^ France Gélinas: Okay. Any idea as to when your commitment to address parking fees would lead to action?

Hon. Eric Hoskins: We've been working diligently on this. I think, as you can appreciate and would probably agree, given the revenue aspect of this, that it is an important revenue stream for hospitals—not all of them, but for some of them. There's significant variation across the province in terms of what's charged for hospital parking.

We've engaged and consulted quite widely, including with the Ontario Hospital Association—those who will be most affected, at least from a revenue perspective. As well, what was tremendously important to me and to the ministry is that we asked HQO, among others, to engage patients and patient advocates to look at it from that perspective of how they're impacted and what possible solutions there might be.

So I can't give you a precise time frame, but much, if not most, of that work has been completed and we expect to have a plan to address this issue in the near future.

M^me^ France Gélinas: In a future yet to be defined?

Hon. Eric Hoskins: As much as any of us can define the future, I suppose.

M^me^ France Gélinas: Okay. Hospital discharges: Right now, if we think that there is a problem with early

discharge, you keep track of the 30-day readmission rate. Is this the only way that we assess whether there are possibilities of a problem with early discharge, or do we do something else?

Dr. Bob Bell: A couple of things: We do, as we've talked about, QBPs. One of the elements of QBPs relates to the development of a best-practice pathway that defines the care of—we've described it—13% of the funding, but probably a higher proportion of the patient care that's provided. For example, for total hips, total knees and for congestive heart failure patients, there's a time that most patients are in hospital. Hospitals have internal review committees, quality-of-care committees, that actually look at that kind of data within their purview.

Under the Excellent Care for All Act, hospital boards are required to have the committees that assess the quality of care received by patients. They are required to survey patients with respect to their satisfaction with the care that they've received. This is one of the elements that's actually questioned on the standard survey that patients fill out. One of the questions that's asked is on satisfaction with education prior to discharge and satisfaction with the discharge process. Hospital boards routinely would be looking at that kind of serial information that's gained through surveying patients.

As you've mentioned, Madame Gélinas, the hospital 30-day readmission for both standard conditions and overall hospital 30-day readmission is one of the elements that is measured within the quality improvement plans that hospitals submit to Health Quality Ontario.

Especially looking at changes, we recognize that hospitals tend to have roughly similar populations of patients being discharged to communities that have roughly similar community resources to care for them. So if we see a jump in the post-discharge readmission rate, the anticipation is that there may be an issue with early discharge, and that's something that hospitals watch and Health Quality Ontario and ourselves watch.

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One of the elements that we think is very important is attendance in the primary care physician's office within seven days of discharge. For our family health teams, CHCs and nurse practitioner-led primary care clinics, one of the quality elements that we have measured in their quality improvement plans is a commitment to see patients within seven days of discharge, which we think is an important element of improving the risk of readmission.

M^me^ France Gélinas: Thank you. I will now go to eHealth just for a minute. In 2013, the previous minister appeared before this committee and she said, "We are on track to have an EMR"—electronic medical record, which I hope right now we call "electronic health record"—"for every Ontarians by 2015."

There are still two months left in 2015, but will we meet this goal and does every Ontarian have an electronic medical record, and if not, where are we at?

Hon. Eric Hoskins: I'm proud of the work that eHealth has done in recent years. Certainly that's an ambitious target and commitment for a government to make, but I'm confident that we are on track for achieving that goal. We have currently more than 12,000 providers who are providing or at least representing well over 10 million Ontarians who have or are in the process of implementing electronic medical records for Ontario patients. As well, I think the figure now is that close to 80% of our primary care providers—primarily family doctors—interact with their patients with the support of an electronic medical record. There are other examples. What's really important to me is the networking that's taking place to allow the various elements of our health care system to communicate with one another. Diagnostic imaging, for example, is fully digitized across the province, and that information is available to practitioners and front-line health care workers, as well as from laboratories.

Significant gains have been made throughout the past number of years, and I would suggest that, for me as well, I was initially focused solely on that commitment of every Ontarian having a record. Now I understand that actually there are many complexities and layers to the system: the digitization, for example, of our diagnostic imaging; our narcotics monitoring system and the ability of pharmacists to be able to interact with that common database; and then the connectivity between hospitals, the ConnectingGTA project here, which Bob, I know, can speak more to.

So there are actually many elements to the electronic medical record system in the province beyond what we often naturally think about when we think of electronic medical records.

M^me^ France Gélinas: When do you figure we won't be in the development stage anymore and every primary care provider will be able to send and receive stuff from the pharmacy, the lab, public health units and the hospital? We're still in development. When do you figure the development will be finished and we will look at version 2 of our electronic health record?

Dr. Bob Bell: Part of the issue here is that people use the health care system in different ways. For any Ontarian who has used a hospital or an emergency department, they would have an electronic health record at that facility. About 88% of Ontarians who have blood tests now: Their blood results are stored in the Ontario lab information system. As the minister has described, folks having images done in hospitals would have an electronic digital record.

I think what you're describing, Madame Gélinas, is the connected agenda of bringing together all digital sources of information at the point of care. That has happened now all across southwestern Ontario. Virtually every primary care provider and certainly all hospitals are linked together and connecting southwestern Ontario. There are about 30,000 users of that connected system in Hamilton and the southwest. That's coming to the GTA right now. There are over 40,000 users. The next step is to move it on to Ottawa, Kingston and the north.

As you know, the NEON system that exists in the North East LHIN connects together Sudbury and the

surrounding hospitals with a clinical data repository that actually enables sharing of information.

Ontario actually stands a fair chance of being the first jurisdiction in the world to bring all sources of digital information together in clinical data repositories. We're going to have three big clinical data repositories: one in the southwest, one in the GTA, and one in the north and Ottawa-Kingston. Those three being connected will actually allow any Ontario citizen with digital health information accessing a primary care provider anywhere in the province to have access to that digital information.

M^me^ France Gélinas: Time frame on that?

The Chair (Ms. Cheri DiNovo): Madame Gélinas, you've got five minutes.

Dr. Bob Bell: Right now it's done in the southwest. It's operative. In the GTA, it will be concluded in the next six months. It's already being planned in Kingston-Ottawa and the north. The timing for that implementation is over the next two years. That will be a truly connected-Ontario achievement.

M^me^ France Gélinas: Would that include a vaccination system that is electronically recorded when the vaccination is given?

Hon. Eric Hoskins: Hopefully. As the ministry behind me will attest to, that was one of the goals which I—if not at that moment, as close to that moment as possible—set for the ministry to see if we could attain it in the future.

If you'll allow me just to give a couple of very brief examples: One of the frustrations that patients as well as primary care providers—family doctors, nurse practitioners—have in their clinics is when an individual has been to hospital and has returned to see their family doctor and there's no hospital report available. There are now more than 700,000 hospital reports that are sent electronically every month to our front-line health care workers to provide that valuable report at the earliest possible time. If you're a senior and you go into an emergency room or into a hospital in this province, that emergency room or that hospital has immediate access to your medication history. It's tremendous, the opportunity—

M^me^ France Gélinas: And that's happening in the southwest? I can guarantee you it's not happening in the north. That's happening in the southwest?

Dr. Bob Bell: That's correct.

M^me^ France Gélinas: Okay.

Dr. Bob Bell: The hospital report manager is providing those reports. Ontario drug information is available in emergency departments—

Hon. Eric Hoskins: Yes, everywhere. Yes, all hospitals and emergency rooms.

M^me^ France Gélinas: Okay. For Panorama—that's the vaccination—last time you were on record, you said that it would be ready by 2016.

Dr. Bob Bell: Panorama actually is ahead of schedule. It has now been implemented in 35 or 36 public health units and is being currently implemented in the last. So we will beat that 2016 deadline. What this represents is a single place for all the immunization data for children, as a starting point, across the province. Public health nurses are uploading their data into Panorama. The regular pre-school visits and pre-school attestation as to vaccination status is uploaded, giving us one central Ontario record with the SNOMED-10 nomenclature that allows us to link to future electronic records.

Your question about whether, rather than carrying the yellow card to the public health unit or to the school to record your immunization data, we could actually do an electronic download of that information: That is currently under pilot testing in the southwest. The expectation is that Panorama can be linked, through this connected backbone technology that we're talking about, to all primary care providers. The technology to download it from the EMRs is being tested right now.

Timeline for that: We don't have it. It's not an approved project now, but there's no technical reason why that can't happen in the future.

M^me^ France Gélinas: Okay.

Hon. Eric Hoskins: It has already proven its effectiveness, right? During the recent measles outbreak earlier this year, particularly in Niagara Falls, the public health unit there was able to—we have more than, I think, six million Ontarians where the data on vaccination status has already migrated into Panorama; nearly 100 million individual vaccination histories. So they were able to pull the information out for contact cases and immediately determine if they had been protected or not.

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M^me^ France Gélinas: I have no doubt that it is useful; I just want to know when it will happen.

Talking about eHealth, when the ministry cancelled the diabetes registry with CGI, the decision protected taxpayers from $46 million in spending, but CGI sued the government and I have numbers that the taxpayer had to pay $26.9 million. I want to know how much the ministry and eHealth paid in legal costs from the CGI lawsuit. Were you ordered to pay the CGI legal costs on top of this? What's the total amount, including the legal costs and the settlement, for the CGI lawsuit?

Hon. Eric Hoskins: I'm not sure whether—I'm not trying to avoid the question at all—but I'm just not—

The Chair (Ms. Cheri DiNovo): You're out of time, actually, so maybe you could table that.

Hon. Eric Hoskins: I'll find out if we're able to, just in terms of any legal considerations—

The Chair (Ms. Cheri DiNovo): Thank you. We're now onto the government side. Mr. Ballard.

Mr. Chris Ballard: I felt that the associate minister—we were starting a really good conversation, especially around First Nation communities. I just wanted to follow up a little bit because of the things I've seen in northern Canada and hearing you talk a little bit about aboriginal and First Nation communities earlier in your discussion.

We know that the children of our First Nation communities often face particular health challenges, and we know that it's so absolutely vital that these communities are provided with an equality of culturally appropriate opportunities for their children to grow and to thrive in.

I'm interested in hearing a little bit more. We started, but we ran out of time. I'm wondering if you can tell me how your ministry has addressed the health challenges.

Hon. Dipika Damerla: Thank you, and I'm glad we have this opportunity to continue that really interesting conversation. I couldn't agree with you more around the idea of making sure that as we roll out our programs across Ontario to help children attain healthy weights—not just in the narrow sense of healthy weights, but general well-being—we make sure that all communities get that equal access, and certainly First Nations are among them.

I just want to speak a little bit about some of the programs the ministry has that are aboriginal or native focused. One of them is called the healthy eating and active living—HEAL; I like the acronym—program, offered by the aboriginal health access centres, AHACs. It reached an additional 450 aboriginal children and their families as of March 2014—an expansion of the healthy eating and active living component of the Urban Aboriginal Healthy Living Program—now this is a less friendly acronym, UAHLP—coordinated by the Ontario Federation of Indigenous Friendship Centres, which is the OFIFC, and fully implemented in 14 of the 29 friendship centres.

I'm going to speak a little bit more in detail about the Urban Aboriginal Healthy Living Program, but I do want to tell the committee how proud we are that since January 2014, the HEAL program expansion has reached more than 2,500 children, youth and their families, participating in physical activity and healthy eating programs within their communities, including First Nations on-reserve.

Just a few months ago, I had the opportunity to visit the Shkagamik-Kwe Health Centre in Sudbury. Actually, I correct myself; I didn't visit the health centre, but representatives of the health centre were at the announcement where I announced that they will receive $525,000 in funding to develop programs that support aboriginal children in the greater Sudbury area and the First Nations of Henvey Inlet, Magnetawan and Wahnapitae. This $525,000 is part of the larger Healthy Kids Community Challenge that we spoke about earlier. The local project will take a holistic approach to fostering healthy behaviours in children and families.

I earlier mentioned the Urban Aboriginal Healthy Living Program, and I just wanted to delve into a little bit more detail. The UAHLP is designed to increase participation and physical activity, and to provide nutrition and smoking prevention and cessation supports to promote healthier living and improved health outcomes for aboriginal people living in urban settings. As an additional objective, the program promotes the capacity of aboriginal youth to lead the change to healthier lifestyles in their communities. The health promotion division funds the Ontario Federation of Indigenous Friendship Centres to coordinate the delivery of the Urban Aboriginal Healthy Living Program across 29 member friendship centres located throughout Ontario. The UAHLP provided $73,000 each, totalling $1.095 million, to 15 friendship centres located in northern regions. So that's just a bit of a snapshot of some of the things we are doing within the aboriginal communities.

I've had the opportunity, and the privilege really, to visit some of these communities. I was up in Webequie, I remember, last fall. That's north of—much, much north of—Sudbury. It is so beautiful when you go on that First Nations reserve. It really is stunningly beautiful, but you come to realize how vast the land is and how isolating it can be, because it's a fly-in community. Everything needs to be flown in. I can only imagine, if you're really young and you're in that community, that it's really important that there is programming that is culturally sensitive, that takes into account the special needs of aboriginal kids. I'm so delighted that we have these programs.

I want to share something else that struck me when I was reading. The objective of the program is to promote the capacity of aboriginal youth to lead the change. I think that is the key; it is about the capacity-building. I say that because my daughter, this summer, spent the summer on Manitoulin Island working with First Nations kids. She helped organize a youth conference for First Nation kids. She learned a lot, but I think what she really learned was the power of seeing youth organize something for themselves. It was very empowering. She came away a much better person, with a huge respect for and realization of the potential and capacity of communities like Manitoulin Island.

I'm really pleased as to what this government is doing. The Premier, as we all know, has a particular interest in ensuring that our First Nations are part of the Ontario fabric.

Mr. Chris Ballard: Very good. Thank you very much. I'll leave it there. That's a really good oversight in terms of what's happening with aboriginal First Nation communities. I thank you for that.

I think my colleague here has another question.

Ms. Indira Naidoo-Harris: Yes. We'll be sharing our time, Chair. My question is for Minister Damerla.

Minister, in my work as PA to health, I often wind up speaking with seniors and their families. I'm working on a dementia strategy, and there are often some really good conversations that I have with seniors and their families. Of course, aging and care for seniors is a top concern and a big topic of our conversations.

Minister, when our seniors need the vital care provided by one of our province's long-term-care homes, we all expect that our parents and grandparents are going to get the highest level of care possible. I know that improving care for seniors has been a large focus of this government. After all, our seniors have given us the best years of their lives, and we want to be able to do the same for them and ensure that they age in a situation and in a place that they're comfortable in.

I also know that our government has made great strides in improving the already high level of quality care Ontarians receive within our long-term-care facilities. However, Minister, one of the areas which residents in

my riding have shown some concern about is regarding the issue of over-prescription of antipsychotic drugs. My constituents want our government to make sure their loved ones are living comfortably and safely with only the appropriate level of pharmaceutical intervention while in the care of one of the province's long-term-care facilities. But this issue does come up. People are concerned about their parents and grandparents and how they're doing and the level of medication they get and so on.

Minister, could you tell us what work is being done to stem the use of antipsychotic drugs in our province's long-term-care homes?

Hon. Dipika Damerla: Thank you, MPP Harris, for that question. I want to congratulate you on the work you're doing on dementia.

Ms. Indira Naidoo-Harris: Thank you.

Hon. Dipika Damerla: It certainly is closely related to the work we are doing around long-term care. You've touched upon an important issue, and I think it's really important to view the prescription of antipsychotic drugs—the appropriate use. That's really important. It's not about too much or too little. It really is ensuring that when they're used, they're used appropriately. As long as they're used appropriately, that is the key.

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To that end, I just want to say that this government has launched a number of initiatives, and I'm glad to share those with you. I'd like to first address the Long-Term Care Homes Act and regulations, which set out very clear requirements relating to the medication management system within long-term-care homes. These requirements ensure the accurate acquisition, receipt, dispensing, storage, administration, and destruction and disposal of all drugs, including antipsychotic drugs, in all long-term-care homes, to meet the medication requirements of residents in a safe and timely manner and ensure the best outcomes for residents.

The regulations also include requirements to address medication incidents, adverse drug reactions, and the use of any drug or drug combinations, including psychotropic drugs, which could potentially put residents at risk. Further, the regulations dictate that a drug cannot be used by or administered to a resident unless the drug has been prescribed for the resident. No person can administer drugs to a resident unless that person is a physician, a dentist, a registered nurse, a registered practical nurse or a nursing student, if the specified requirements set out in the regulations are met.

I also wish to note that long-term-care homes must ensure that residents are not restrained by the administration of a drug to control the resident, other than under the common-law duty described in section 37 of the Long-Term Care Homes Act.

I just laid out these regulations to give comfort to the residents that there are many checks and balances under the act and under regulations as to how and when any drug—in particular, antipsychotic drugs—can be used. While I know that the regulations represent a starting point, our government knows that regulations are only one tool in that toolbox.

I'm proud to tell this committee that in the summer of 2015 I issued a letter to all Ontario long-term-care homes requesting that they include appropriate prescription of antipsychotic medication as part of their quality improvement plan. Quality improvement plans are something that long-term-care homes use to improve their quality, and they can pick the areas that they think they would like to improve on. What this letter did was ask every long-term-care home to ensure—it was a request, of course, and most of them complied—that if they had not thought of putting antipsychotic drugs as one of those key indicators that they wanted to show improvement on in their quality improvement plans, then could they please do that? I'm pleased to say that the vast majority of homes do now have ensuring appropriate prescription of antipsychotic drugs as one of their key points in their quality improvement plans.

These quality improvement plans, you will be interested to know, have now become mandatory for long-term-care homes. They've been mandatory in hospitals for quite some time, but for long-term-care homes they were voluntary. But beginning in 2015, they became mandatory for long-term-care homes as well. They're a powerful tool to keep moving along that quality improvement.

The government is asking long-term-care homes and sector partners to enhance their efforts by leveraging two other key initiatives. The first is called—I've spoken about the quality improvement plan, which outlines an LTC home's commitment to its residents, staff and community. The second is our continuing partnership with the Ontario Medical Association to support long-term-care homes with appropriate prescribing through an appropriate prescribing demonstration project focusing on antipsychotic medications.

This program will deliver on a provision of the 2012 physician service agreement related to the opportunity to support appropriate prescribing through voluntary quality-based education strategies. As part of the appropriate prescribing demonstration project, which was launched this fall in long-term-care homes, all members of the interprofessional care teams in participating long-term-care homes will have the opportunity to use evidence-based tools to evaluate and improve prescribing patterns, where appropriate.

I'm also pleased to say that the vast majority of physicians who practise in long-term-care homes have also signed—we were surprised as to the number of people who voluntarily signed up to get some of this feedback. Prescribing physicians and nurse practitioners will have access to their confidential personalized practice reports, with a focus on prescribing patterns as well as focused educational outreach sessions to support evidence-based prescribing.

In laypersons' terms, how this would work is, every doctor would get a report of their own antipsychotic prescription history, but they would also get a risk-

adjusted anti psychotic prescription history of their peer group. It would show how they are prescribing, and they would compare it to their peers who are prescribing antipsychotic drugs in very similar acuity cases. That gives doctors a chance to see, "Am I prescribing within that average range? Am I prescribing beyond that average range? Am I prescribing below the range?" It really is a learning tool because you can compare with professionals who are your peers. Then we have detailers who would actually work through those reports to help physicians make sure that when they prescribe antipsychotics, it's appropriately done.

This is a really powerful tool in collaboration with Ontario physicians. We're really looking forward—I think the combination of these many initiatives, the safeguards that are already there in the long-term-care act, the appropriate prescribing of antipsychotics working group, the fact that we've asked all of our long-term-care homes to include appropriate prescribing as part of their quality improvement—

The Chair (Ms. Cheri DiNovo): I'd remind Ms. Naidoo-Harris that you have about five minutes left; actually, just a little under. Thank you.

Hon. Dipika Damerla: These are some of the examples of what we are doing to ensure that the prescription of antipsychotics is appropriate.

Dr. Bob Bell: Actually, I have to pay tribute to the associate minister for her insistence that all long-term-care homes include this element of quality improvement in their quality improvement plans. Previously, long-term-care homes were able to select this as one variable, but the associate minister wrote to all long-term-care homes, encouraging them to include this if they weren't already practising a best practice. I think that demonstrated the importance this represents to the ministry and the leadership that the associate minister is taking in improving quality within the long-term-care community.

Hon. Dipika Damerla: Thank you, Deputy.

Ms. Indira Naidoo-Harris: Thank you so much, Minister, for that detailed and informative answer. It's really encouraging to know that very appropriate measures and checks and balances are in place to ensure that we are creating a safe environment for our seniors to age in. It's really very good to know that we are doing the best we can to deliver the highest-quality care for our seniors in this province.

I'm just going to ask you a quick question on a related matter. We probably only have about two or three minutes, but I think it's germane to the conversation that we're having right now. I'm interested in hearing a little bit of detail about how the safety of long-term-care residents is being protected when it comes to the issue that long-term-care-home residents are facing increasingly complex health and behavioural challenges. Beyond regulation and monitoring of antipsychotic medications, what is the government doing to address these unique challenges and what I hear is an increase of some of these behavioural challenges that we're seeing in these facilities?

Hon. Dipika Damerla: Thank you, MPP Harris, for that question. It really makes for a nice segue, because I do want to talk about a program that we have, which is Behavioural Supports Ontario, which really is—and I'm not a medical practitioner; Deputy Bell will weigh in if I'm getting this wrong. When you are trying to address aggressive behaviours, behavioural supports is probably the opposite end of using drugs to manage behaviour. Here, what you're really trying to do is find out what is actually triggering those behaviours, and then, what can you do to support the individual so that those triggers are minimized and the behavioural patterns and aggression are minimized. The intervention, as much as possible, is to get away from drugs and to intervene through supports and counselling. That, in layman's terms, is Behavioural Supports Ontario. The ministry created BSO to help people with challenging and complex behaviours, whether they live at home, in long-term-care homes or elsewhere. Behavioural Supports Ontario also supports families, health care professionals and the health care system.

Through BSO, a provincial framework of care was implemented across the 14 local health integration networks which integrates new, locally appropriate service models, including the establishment of long-term-care homes, specialized behavioural units, and behavioural outreach teams. Standardized care pathways, best practices and measurements were supported by Health Quality Ontario. BSO has been successful in establishing foundational health human resources capacity and other resources to support the care and safety of individuals with complex and challenging behaviours.

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The Ministry of Health is providing local health integration networks with annual funding of about $44 million to sustain Behavioural Supports Ontario and ensure staffing capacity to meet the needs of individuals with challenging and complex behaviours where they live. To date, LHINs report that base funding has supported the hiring of 604 full-time employees to support BSO initiatives. What's really nice about our model is that it's very flexible. Certain homes may choose to have a resident person who delivers BSO-type expertise. Other LHINs rely more on a mobile unit, where experts can come to a home—

The Chair (Ms. Cheri DiNovo): I'm afraid that is all the time you have on the government side. We now move to the official opposition: Mr. Walker.

Mr. Bill Walker: Thank you very much, Chair. Welcome, everyone. Good to be back again. I think we finished off last time—Minister, I was asking for some numbers, and you asked me to be fair, so I have been fair. I've given you the weekend, and back here again. I'm not certain if you have the one with the 90,000 new seniors that we're going to get care for—that was the question I asked. If you haven't got it, that's fine, and we'll know that you'll follow up on that another time and I'll just move on to other questions.

Hon. Eric Hoskins: Bear with me just a second. Can I just read this? This will provide—

Mr. Bill Walker: Sure, and I'll be more succinct. When I had asked: Did you promise 90,000? I don't want to know anything about process and transition and studying; I just want to know. You said "90,000." How many have actually received it? And if you don't have that, I'll just move on to other questions. We can get that at a later date.

Hon. Eric Hoskins: I'm just looking at—and I can't remember the reference year—the first year that is referenced.

Mr. Bill Walker: In 2013, in Ontario's Action Plan for Seniors.

Interjections.

Mr. Bill Walker: Okay, can we just park that while she's doing that so that we're not wasting a whole bunch of time here?

The other question is that I want to talk a little bit about the diabetes registry with CGI. My colleague France Gélinas had started to talk about that. I really want to know how much you have paid as a government to CGI for a diabetes registry system that we actually don't have, so including all legal—any costs associated for consultants; anything to do with the litigation. I want to know the exact cost. How much has it cost the Ontario taxpayer for the CGI program that we don't have?

Hon. Eric Hoskins: I think, due to the breadth of your question in terms of the detail that you're asking for, I would ask my ministry to look into providing the answer to that question.

Mr. Bill Walker: I would appreciate it. Thank you. That's great.

Moving on a little bit to falls prevention and physiotherapy: It's two combined areas here. You're talking in some of your documentation that you have added another $1.5 million, I believe you stated when we talked about this earlier.

Hon. Eric Hoskins: This is with regard to?

Mr. Bill Walker: Falls prevention and physiotherapy.

Hon. Eric Hoskins: Yes.

Mr. Bill Walker: So you had said that you added $1.5 million, but you actually took $50 million out of the system. What I'm trying to get my head around is: Did you also at that point put any processes in place so that when you've cut those physiotherapy services or falls prevention services out of the various facilities that seniors are in—what I hear anecdotally when I'm touring the province in facilities is that people are actually having more challenges. They're heading to the emergency department because of these falls, which is costing us more. So what I want to know is, you actually took it out with a savings—and I appreciate that you thought there were some challenges with the program of how people were getting physiotherapy. It wasn't a good service, and I acknowledge that you did that and I would support you in that. But the opposite side of that is, if other people who truly need the services aren't getting them, and they are falling—and what I'm hearing, particularly on the long-term-care side, is that people are not getting it. Their mobility is actually decreasing, which is leading to more challenges, more falls, and that's again increasing our most costly form of health care, which is the emergency department.

Hon. Eric Hoskins: Thank you. While I'm just trying to reference the financial aspects of the question that you're asking, and perhaps it may be that the ministry behind me can help me source that, but just with regard to the program changes that were made several years ago, maybe I'll provide the context. As you know, there was a select number—very few across the province, and not even appropriately distributed in terms of population or need—that were the beneficiaries of government-funded physiotherapy services through the physio clinics themselves. It was felt that it was appropriate to create a new model, a model that I think you reference that you support. That also gave us the opportunity to create a substantial investment that is estimated—I think the figure is 200,000 individuals that would benefit from the falls prevention programs.

Perhaps, are you in a position to comment?

Dr. Bob Bell: Associate Deputy Minister Nancy Naylor has got some numbers for you.

Ms. Nancy Naylor: Sure. When the change was made, funding for physio that had been initially funded through OHIP was converted to funding that was directed through a number of ways directly for patients. I'll just read a couple of examples of that.

CCACs received $33 million to begin providing in-home physiotherapy; long-term-care homes received $58.5 million for one-on-one physiotherapy, plus $10 million for group exercise and activation programs. In addition, there was funding provided for a community exercise and falls prevention initiative: $10 million as a base. On top of that, as the minister referenced on one of the former dates, we have added a million and a half for LHINs to support falls prevention classes—

Mr. Bill Walker: I get that you're adding more money to the system, but what I really want to get back to is: How many people are getting more service, and how many people are not getting service as a result of the change?

In a large geographic rural area like mine, you have moved to a system where people that might be 30, 40 or 50 miles away aren't going to drive there, certainly in the wintertime. They're elderly, so they're not going out in the evening. So if that class is moved to one spot and they're expected to get there, they're not doing it.

My concern is now that they're not taking physiotherapy. Their actual health is getting worse and they're going to end up reporting to the ER at some point, either due to a fall or less mobility.

What I'm just trying to ascertain is: Did you take that into context and are you looking at the opposite side? I can get all the time that you put in more money and what your projected expectancy is to increase some of those people. Are you doing the equivalent on the opposite side for who is not getting services? Because what I'm hearing from the front line and from the seniors is that they are not getting the services. They used to get a

number of appointments and now they're cut back to 12. They used to maybe need 40, and they're getting 12 now. That to me is not an increase in service; that's a decrease. I'm just trying to figure out on behalf of those people where you went with that.

Ms. Nancy Naylor: Our view is that these changes have actually resulted in more Ontarians receiving physiotherapy services. Our count is that over 200,000 more Ontarians can now access physiotherapy. I think what you are referring to is the fact that some of that is funded in what are called episodes of care, but certainly that is renewable. There are episodes of care, for example, in a community clinic, funded for a couple of hundred dollars or about $300 for about eight sessions. If a patient needs more than that, that's certainly renewable and they are certainly eligible for as many episodes of care as they require.

Mr. Bill Walker: Ms. Naylor, I hear the 200,000. We'll just park that one, if we can. What I'm trying to suggest to you is that there are number of people who are not getting the same level of care. They are slipping backwards and they're going through different forms of health care, which is costing us more money to keep them at the same state. That's my concern. There are a number of people, physiotherapists included, saying, "I used to give Mrs. Smith 10 sessions or 12 sessions or 25 sessions," and now she is not getting them and she is expected to go down the road 30 miles to find that. That's not an improvement in care. I'm trying to get my head around: Are you measuring the people, as a result of your change, who are actually presenting on the negative side of the ledger? Have falls increased in any of the facilities?

Hon. Dipika Damerla: If I can just take a minute—I think Minister Hoskins can talk more broadly as well—I just wanted to reference that in long-term-care homes, we do have certain statistics that you might be interested in.

Before we broadened the changes, on average, about 85% to 100% of all long-term-care residents received physiotherapy, with many physiotherapy services delivered as an exercise class. So we're aware of the fact that it wasn't really physiotherapy as we understand it: not one-on-one, but a lot of it was through exercise classes. Now, on average, 70% of residents in licensed beds receive one-on-one physiotherapy. So in terms of the quality of care, we feel we have really improved.

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I think the really interesting data is that average minutes of physiotherapy per long-stay resident increased from 19.8 minutes per week in December 2013 to 27.2 minutes in June 2014. So that actually shows an increase in the amount of that one-on-one physiotherapy that long-term-care residents are getting.

We fund long-term-care homes based on the acuity in the needs of every single individual resident. So if they require physiotherapy, they get physiotherapy. What we moved away from, as you know, is a model where exercise classes were being billed as physiotherapy. I think the evidence and the numbers here suggest that it's better care.

Mr. Bill Walker: I applaud that. Again, if it was a physical activity program that wasn't truly physio, I get that and I support that. That's not the need that we want.

Can I just ask for a point of clarification, though, Minister? If a resident in a long-term-care facility was deemed to be assessed and had a care plan that needed 112 appointments in a year, are they guaranteed to get that 112?

Hon. Dipika Damerla: I'm going to take a stab at this answer, but I'm going to ask the deputy to weigh in. My understanding is that physiotherapy tends to be, by definition, a limited course. If you need 112 appointments, then at that point, it's probably a different kind of care. Physiotherapy is typically a course with defined beginnings and ends. I'm going to let the deputy speak to—

Hon. Eric Hoskins: There were no changes made to the units of care that could be provided. You had suggested that there might be a cap of 12. That's an erroneous assumption. In fact, it remains to the primary care provider to determine the course of care that is required. There may be a requirement to return to that primary care provider after a certain number of units of physio are provided, but there is no cap. That aspect of the care was unchanged.

I think it's also important to emphasize that for a lot of the individuals who were receiving care, whether in a long-term-care home or other type of residential setting or even in their homes themselves, that care is continuing. It may be that, for example, the group physio classes that were taking place under the old system, where there could be quite a large number of individuals who were essentially doing exercise classes or falls prevention classes and the like, that activity is continuing, it's just continuing funded through that tranche of the falls prevention or group exercise classes. Individuals who have been deemed unable to leave their homes but require a course of physiotherapy care will still get that physiotherapy care.

I would argue that we've actually expanded the opportunities for individuals, including the home, for those who require it in the home—certainly, if that home happens to be a long-term-care facility, for example. We're confident with that number: in excess of 200,000 additional Ontarians are able to avail themselves of either physiotherapy or falls prevention classes—

Mr. Bill Walker: I am hearing though, Minister—just to counter what you said earlier—from physiotherapists who have said, "I've had patient X for the last five years. They had 48 sessions with me in the last five years, annually. I assessed them. They needed that; that keeps them mobile. It's a continuum of their care to ensure that. I was told that they did have to go back to 12, and they could apply to get more, and they had to go through yet another process." We talk often in the House of administration and bureaucracy; if someone had 48 or 52 or whatever that number happens to be, and they've been assessed by a professional physiotherapist, why all of a sudden this year do they only need 12 and have to go through a process?

What I struggle with is when someone has that type of care and has had it for long periods, why we put them through that whole process. We're spending money on administration, not on that person getting what they want, and in the worst-case scenario, they lose some of that mobility and they have challenges.

I think we're moving in a good direction. I think you're getting a sense of the type of concern that I'm hearing in my community and I hear across the province when I'm in long-term-care facilities or retirement homes. There are people who are not getting the care, I'm hearing that very directly. Again, Associate Minister, you've said 70%; that's wonderful. The goal should be 100%. I'd like to see your numbers that are going to suggest that you want to get to that 100% so that the people who truly need physio are getting the physio, and we're not putting limits and going through administrative processes to get there.

Hon. Eric Hoskins: We haven't introduced limits and we haven't introduced additional administrative barriers. Really, it's about appropriateness of care and following good clinical guidelines. If it is deemed by that health care professional that that individual requires a certain amount of physiotherapy, they're entitled to it and they'll get that physiotherapy.

I know that, certainly, at the beginning of the transformation of this process, there was a misconception in the province that, somehow, we were limiting the course of care. That has not been the case. We have not put any limitations on it.

Mr. Bill Walker: I can assure you, Minister, as recently as August, I was in a long-term-care facility in Midland that shared exactly those types of concerns. That misconception, if it was there, remains. I can give you three or four that I visited personally which still have those concerns and shared them very directly with me as the critic, saying, "This is the issue I have." You're not meeting the standard. You're not meeting the requirements of the patient.

They, again, are supportive of the whole group thing. If that was being missed and abused, I'm the first guy to step up and say: I want to support you with those types of things, but not at the expense of people who truly need that care and/or people who are getting missed now in the system because there isn't funding in the system.

Hon. Dipika Damerla: The Long-Term Care Homes Act is very clear that every resident must have a care plan that meets their needs. If that care plan says that they need physiotherapy, then they get physiotherapy. So the act is very clear that residents get the care that they deserve, whether it's physiotherapy or any other medical therapy that they need. My expectation is that long-term-care homes are creating appropriate plans and then delivering on those plans—

Mr. Bill Walker: What I will do is I will bring the minister some cases—

The Chair (Ms. Cheri DiNovo): Mr. Walker, you have about five minutes.

Mr. Bill Walker: —thank you—and explore those.

Another one that I just wanted to touch on very quickly, since we only have five minutes: You set a target in 2013 to implement a provincial program to help seniors living with Alzheimer's and other dementias. How many of the 629 LTC homes in Ontario have implemented this program to date? How much was targeted to be able to meet that target? How much was actually spent on the front-line programs and services? If all of the money wasn't spent, I'd like to know where the difference was spent.

Hon. Dipika Damerla: I know that building specialized units across long-term-care homes, as required, whether it's for behavioural things like Alzheimer's or dementia which you mentioned, is definitely work that's already under way. As you know, we have a dementia strategy that Parliamentary Assistant Naidoo-Harris is working on. I'm going to turn to the deputy to answer the more technical pieces of the question.

Mr. Bill Walker: If I could, though, I just want to clarify a little bit. My messaging the last time, as well, was that you come out and you set a number in front of the public of Ontario, saying "I'm going to have 629 homes get this." I would expect, and the people of Ontario that come to me are expecting: When and where is this going to happen? If you've got 629, are you setting a five-year goal? Are you setting a two-year goal? Open-endedly saying, "We will get there and are in process," frankly, Minister, is not good enough. We want to know: Are you on track? If you don't have a plan, that leaves me equally disturbed in regard to—you're making grandiose plans. You're throwing grandiose numbers in front of the public, but you're not hitting the targets. They have expectations. It's no different than anything that I do in my personal life. If I'm going to build a house, I say that I'm going to do in the next six months or I'm going to do it in a year, and I want to know that that contractor is on target or I'm going to hold him or her accountable.

It's no different here: If you're going to say things like, "I'm going to put in 629 programs," then I want to know where you are on your scale of 629 programs.

Hon. Eric Hoskins: That's a valid question. Certainly, I think that it's a question that the ministry can look into.

Dr. Bob Bell: Can we ask you just to be a little clearer, so we can come back, Mr. Walker, with the appropriate answer for you? We were a little unclear.

Mr. Bill Walker: Again, you set a target in 2013 to implement a prevention program to help seniors living with Alzheimer's and other dementias. How many of the 629 long-term-care homes in Ontario have implemented this program to date? How much was targeted to allow them to implement these programs to date? How much was actually spent of what you had budgeted to do? And if you didn't spend all of the money to get that, on a time frame that I trust you should have defined, then where did the money go?

Hon. Dipika Damerla: What we are going to do is—what I can assure you is that long-term-care homes across Ontario already have specialized units. What we can do is

consult with the ministry to see what kind of data we can provide you on that. I'm going to consult with the ministry and see what's possible.

Mr. Bill Walker: I appreciate that. The other question—because I know that I'm probably getting right down to the last couple of ticks—is that there are approximately 800,000 people without a physician. Can you give me a breakdown of how many seniors of that 800,000 are without a family physician, how many people in middle age are without that, and how many children are without a family physician across that 800,000 that remain without a physician, across our province?

Hon. Eric Hoskins: Again, that's a question that I can ask the ministry to look into. I know that that is an estimate based on a survey. I'm not aware—but I suspect—if we obtained the demographic data that you're requesting as part of that survey which lead to that figure, but I certainly will ask the ministry to look into it.

Dr. Bob Bell: It would strictly be an estimate based on the survey data and the folks who are answering. We won't have exact data.

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Mr. Bill Walker: Not expected, but my thinking again is, if you at least know who the target audience is, your strategies are following how to serve that demographic or those demographics best. If you don't know how many, how are you then training the doctors who are coming out of school for the actual need that we have?

Dr. Bob Bell: Anecdotally, what we do know is that there's a high proportion of those 800,000 people who are young, healthy—generally speaking—males who—

Mr. Bill Walker: You just described me.

Dr. Bob Bell: There you go—who may have decided like you that they may or may not need a family doctor. Their health is such that they don't need access to a health care provider. We know that's a significant chunk of the folks who don't have access to primary care: people just like you.

Mr. Bill Walker: Okay. Thank you very much.

The Chair (Ms. Cheri DiNovo): We now move on to the third party: Madame Gélinas.

M^me^ France Gélinas: All right. When I left off, I was asking about how much the legal costs were for the ministry and eHealth for the lawsuit from CGI about the diabetes registry. My colleague asked for a broader list of expenses, not only the legal expenses, but consulting expenses. But I want to make sure that those are not only to the ministry, but also to eHealth, and then I'm satisfied with the answer you've given him.

Hon. Eric Hoskins: Okay.

M^me^ France Gélinas: My next question has to do with lawsuits. How many lawsuits against the Ministry of Health do we have right now?

Hon. Eric Hoskins: I'm going to have to ask the ministry to look into that as well. I'm not intimately familiar with that.

M^me^ France Gélinas: Okay. My next question has to do with lawsuits, but I will set you in context. How many out-of-country funding applications do we receive each year? I'm up to date till 2012, so I'd like to know—2013-14 and 2014-15: How many out-of-country funding applications we received, how many were approved, how much was budgeted and how much was spent for those two time periods?

Hon. Eric Hoskins: Okay. Before me, I certainly have, in the first instance, information for the funds expended for out-of-country health services. Do you want me to read that into the record?

M^me^ France Gélinas: Sure.

Hon. Eric Hoskins: Going back to 2010-11, it was $54.4 million; 2011-12, it was $33.5 million; 2012-13, $39.1 million; 2013-14, $43.5 million; and 2014-15, $56.4 million, which is the last year that we would have actuals for.

In terms of the numbers of patients that were served—you have to point me to—what's the number?

Interjections.

Hon. Eric Hoskins: The total number of patients—what was your question with regard to the total number?

M^me^ France Gélinas: I wanted to know how many people had made applications, how many got it and how many got turned down.

Hon. Eric Hoskins: I only have those approved before me. Unless they appear in the next moment, can I suggest that that's something I ask the ministry to look into as well?

M^me^ France Gélinas: Sounds good.

Hon. Eric Hoskins: But if you're interested, I can certainly tell you that in the last year that we have complete numbers for, 2014-15, there were 14,481, I believe—certainly in excess of 14,000 Ontarians who were approved and did avail themselves of out-of-country health services.

M^me^ France Gélinas: Let's say we take this number for last year. We spent $56.4 million for 14,481 Ontarians to receive out-of-country coverage. Do we know how many of those were for addiction services?

Hon. Eric Hoskins: I don't offhand, but if you'll allow me on the previous question just to provide some supplemental information. As of Q1, the first quarter of this fiscal year, 93% of out-of-country applications have been approved.

M^me^ France Gélinas: Okay. You do keep track, so you'll be able to give me the percentage for the other ones, too.

Hon. Eric Hoskins: I'll certainly ask the ministry to look into that.

M^me^ France Gélinas: And can I have the percentage of those, or the number—once I have the number, I can figure out one or the other—that were for addiction services?

Hon. Eric Hoskins: That's a question that I'm sure the ministry is taking note of, if I can consult with them on the data.

Dr. Bob Bell: The one thing we can say, Madame Gélinas, is that especially with respect to eating disorders, we've pretty substantially increased capacity in

the province that allows us to treat patients within Ontario rather than sending people out of country for that kind of mental health service, as well as some expansion in our addictions. I can't give you the exact data on that, though.

M^me^ France Gélinas: Okay. Why is there a lawsuit against the government on this issue?

Hon. Eric Hoskins: It's a pause as we—

M^me^ France Gélinas: The awkward silence.

Hon. Eric Hoskins: It's just becoming fairly frequent to—

Dr. Bob Bell: We actually have one of our ministry lawyers here, but we don't have any information.

Hon. Eric Hoskins: So we're going to have to look into that as well, if that's all right.

M^me^ France Gélinas: Okay. So the information will come—

Hon. Eric Hoskins: But a lawsuit—because there is an appeal process that's available to individuals who were denied the out-of-country coverage, but you're referencing something else. You're referencing an actual legal process outside of the appeal process that is available.

M^me^ France Gélinas: Correct. I'll change the topic again, because this is my last rotation of 20 minutes.

Hon. Eric Hoskins: It feels like Jeopardy—

M^me^ France Gélinas: Yes, exactly. Hospices: Can you give me a list of how much funding was given to hospices? I'd like to go back to 2013-14 and 2014-15. What was the amount that was budgeted, the amount that was spent and why is it that we don't fund hospices to 100% of their expenses, but only fund certain parts of hospice services?

Hon. Eric Hoskins: Generally speaking, we were the first government to fund hospices in Ontario. We currently fund, I believe it's—I don't think it's 20; I think it's in excess of 20 hospices that we're funding. We made a commitment to fund an additional 20 as well on the operating side. That's work that my parliamentary assistant John Fraser is working on right now to fulfill that commitment of government.

With regard to the portion of funds that we provide on the operating side, partly I think it's recognition that the capacity, as we do in other aspects of the health care system, of our hospices and those individuals who work with them or volunteer their time—often the communities are strongly supportive of our hospices, and there is a significant fundraising capacity that takes place as well. To both avail ourselves as a province of the fundraising capacity to assist our hospices, but also for us to be able to provide a significant amount of funding over a larger cross-section of hospices, I would presume that that's part of the reason why we would fund part but not all. But I may have a better answer coming here. I hope you can appreciate that I'm being as forthcoming as I can. I don't pretend to have all the answers to all of your very valid questions.

So 34 existing hospices are funded through CCAC budgets, and we fund at the level of $90,000 per bed per annum, and $134,000 per pediatric bed. So we don't have what the total of that is province-wide, currently, in front of me.

M^me^ France Gélinas: Okay. So one envelope, $90,000 per bed, and that's—

Hon. Eric Hoskins: For adult hospice beds, yes.

M^me^ France Gélinas: For adult, and $134,000 for—

Hon. Eric Hoskins: And pediatric, $134,000.

M^me^ France Gélinas: Okay. I'm moving on to the Northern and Rural Recruitment and Retention Initiative. In the fall of 2013, there were 319 northern and rural recruitment and retention grants. I'm interested in knowing what was the amount of grants, in money, given in 2014-15? How much is budgeted for 2015-16? And how many grants have been awarded each year for let's start in 2013-14, 2014-15 and this year, if you have it?

Hon. Eric Hoskins: Okay. Just bear with us for a second just to see if we have this information before us or if that may be something that I need to ask the ministry to find.

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So what I do have before me with regard to the Northern and Rural Recruitment and Retention Initiative is that to date—this may or may not answer your question, but I'll start with this—the ministry has approved over $40 million in funding for 560 Northern and Rural Recruitment and Retention Initiative grants across the province.

My understanding is that it began with an initial allocation of $5.4 million, which has been increased to—$7.9 million is the allocation for this fiscal year, 2015-16. And that's really due to an increase in the program uptake, which is a good thing. I think we would agree, and I'd like to stress the importance of this program because it really—particularly for those communities that are otherwise unable to attract physicians and specialists, or where patients wouldn't have access to primary care, this provides an opportunity to do just that.

M^me^ France Gélinas: Oh, absolutely. This $7.9 million is for 2015-16; how much was it last year and the year before?

Hon. Eric Hoskins: I don't have that in front of me. I'll add that to the list of information I'll consult with the ministry for.

M^me^ France Gélinas: The other one has to do with primary care—family health teams, aboriginal health access centres, community health centres, nurse practitioner-led clinics and birthing centres. I would like to know the amount that was spent, in dollar amounts, for each of those programs over the years. I'm good until 2012, then there's this blank. So 2013-14, 2014-15 and 2015-16: How much money was spent on each of those—

Interjection.

Hon. Eric Hoskins: My deputy assures me that he's going to miraculously reveal this information, hopefully.

M^me^ France Gélinas: I ask it every time, so I'm sure somebody said, "She's going to ask that again."

Hon. Eric Hoskins: We should have at least been able to predict it.

M^me^ France Gélinas: Yes.

Interjection.

Dr. Bob Bell: That's great. Thank you.

The interprofessional primary care models, if we start back in 2011-12: for family health teams, $309 million in 2011-12; $316 million in 2012-13; $337 million in 2013-14; $345 million in 2014-15; and the allocation hasn't changed this year. That excludes physician payments but includes health links funding.

If we look at nurse practitioner-led clinics, starting in 2011-12 it's $29 million; 2012-13, $35 million; no change in 2013-14; and no change in 2014-15 or 2015-16 allocations.

Aboriginal health access centres: $20 million in 2011-12; $21 million in 2012-13; $22 million in 2013-14; and $23 million in 2014-15.

If we look at community health centres: $84 million in 2011-12; $86 million in 2012-13; $85 million in 2013-14; and $85 million in 2014-15.

The amounts for 2011-12 to 2014-15 are actual expenditures. For 2015-16, the numbers we mentioned are, of course, allocations.

M^me^ France Gélinas: Birthing centres?

Hon. Eric Hoskins: I was just looking to see how that wasn't on this—we should have figured that one out. Does anybody know if we have the information on birthing centres? If not, that's something that we—assuming that we have it—can provide. I'm sure we have it.

M^me^ France Gélinas: Can you separate out the health links money to see how much funding has been provided? And I would like it for each health link.

Dr. Bob Bell: We certainly have the money that we budget for health links.

Hon. Eric Hoskins: So we might have the global amount and then we'd have to get back to you with regard to the individual health links. That's something that I'd have to ask the ministry to look into.

M^me^ France Gélinas: Okay. They're not very old, so go as old as they get—whenever they started.

It's interesting. If we take, let's say, aboriginal health access centres or nurse practitioner-led clinics that have had, like, $35 million, $35 million, $35 million, how do you address their wait-list when the budget doesn't change year over year?

The Chair (Ms. Cheri DiNovo): Madame Gélinas, you have five minutes left.

M^me^ France Gélinas: Okay.

Dr. Bob Bell: Should we come back to health links?

M^me^ France Gélinas: Oh, sure.

Dr. Bob Bell: The funding history for health links, starting in 2012-13: $1.4 million; 2013-14, $8.6 million; 2014-15, $18 million; and 2015-16, $19 million. That's the allocation in 2015-16. That doesn't include, in 2015-16, a more recent allocation, a funding package of $1.1 million which will support the North East Local Health Integration Network for implementation of five health links.

M^me^ France Gélinas: Okay. Will I be able to get it health link by health link?

Dr. Bob Bell: The funding is pretty consistent, but we could—I think the request is to know where these health links are. Is that the—

M^me^ France Gélinas: Partly. You see right through me, don't you?

Hon. Eric Hoskins: So can we ask the ministry to look into that as well, to that level of detail?

M^me^ France Gélinas: Yes, sounds good; much appreciated. My question was, if you flatline, how do you address wait-lists? If we look at nurse practitioners. there have been $35 million assigned to those 25 nurse practitioner-led clinics for the last four budget years, but some of them have long wait-lists. How do you address that?

Dr. Bob Bell: I think it's fair to say that we've got a variety of different models of providing primary care. Team-based models, as you know, also include nurse practitioners working within professional health teams. We continue to increase that allocation for primary care based on about a 1.25% increase to the physician services budget this year and the following year.

M^me^ France Gélinas: None of this has anything to do with nurse practitioner-led clinics.

Dr. Bob Bell: Not nurse-practitioner-led clinics, but nurse practitioners providing primary care within the family health—

M^me^ France Gélinas: No, my question was specific to the nurse practitioner-led clinics. I have many of them in my riding. They all have long wait-lists and they've been flat—not only have they been flat, but you've just read 35-35-35-35, which means that for the last four years the total amount was $35 million for those 25 clinics.

Interjections.

M^me^ France Gélinas: I take it that we don't. All right. I'll go to my other question, then. You have said many times that 75 new nurse practitioners in long-term-care homes—30 of them were announced this fall and 45 will follow in the following years. How many long-term-care homes will be served altogether? Of the 30 that were announced for this year, how many have been hired?

Hon. Dipika Damerla: My understanding is that there will be 75 long-term-care homes that will eventually have 75 nurse practitioners. We've started the hiring process, but I'm going to turn to the deputy or staff if they actually have an update on how many have been hired to date or what that status is.

M^me^ France Gélinas: So of the 756—if my memory serves me—good long-term-care homes, 75 of them will have a nurse practitioner and the other 700 won't?

Hon. Dipika Damerla: The way the program works is, what we looked for was long-term-care homes that have a demonstrated gap in providing primary care to their residents. It was really based on which homes needed it. Some homes may have already excellent access to primary care on-site; others need it. It was

really based on a gap analysis. That was the primary driving feature.

In terms of where we are in the rollout of those first 30, I'm happy to consult with the ministry and see if we can get back to you on that issue.

M^me^ France Gélinas: Thank you. I'm interested to know if the ministry has done any polling or public opinion search about the physician compensation negotiation, how much money was spent on doing public-opinion-polling-type research on this issue, and what was the result.

The Chair (Ms. Cheri DiNovo): I'm afraid we've come to the end.

M^me^ France Gélinas: You're saved by the bell.

The Chair (Ms. Cheri DiNovo): Maybe that could be submitted. Thank you; we are now adjourned until tomorrow at 3:45.

The committee adjourned at 1800.

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Tuesday 3 November 2015

STANDING COMMITTEE ON ESTIMATES

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Ms. Indira Naidoo-Harris (Halton L)

Also taking part / Autres participants et participantes
Mr. Bill Walker (Bruce–Grey–Owen Sound PC)
Mr. Jeff Yurek (Elgin–Middlesex–London PC)

Clerk / Greffier
Mr. Christopher Tyrell

Staff / Personnel
Ms. Heather Webb, research officer,
Research Services