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Wednesday 8 June 2016

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Mercredi 8 juin 2016

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
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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON ESTIMATES

Wednesday 8 June 2016

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DES BUDGETS DES DÉPENSES

Mercredi 8 juin 2016

The committee met at 1556 in room 151.

MINISTRY OF HEALTH AND LONG-TERM CARE

Le Vice-Président (M. Michael Mantha): Bonjour. On va reprendre le travail du Comité permanent des budgets des dépenses. Bienvenue cet après-midi.

Good afternoon. We are here to resume consideration of vote 1401 of the estimates of the Ministry of Health and Long-Term Care. There is a total of three hours and 24 minutes remaining.

Before we resume consideration of the estimates, if there are any inquiries from the previous meetings that the minister or ministry has responses to, perhaps the information can be distributed by the Clerk at the beginning in order to assist the members with any further questions. Are there any items, Minister?

Hon. Eric Hoskins: No, but can I move unanimous consent that we dispense with the remaining three hours and 20-odd minutes?

Hon. Dipika Damerla: I second that.

Laughter.

The Vice-Chair (Mr. Michael Mantha): Nice try. And with a Chair who has to rush home with his youngest son who is graduating, you almost had me there.

When the committee adjourned yesterday, the third party was about to begin their 20-minute round of questions. Madame Gélinas, le plancher est à vous.

M^me^ France Gélinas: Merci, monsieur Mantha. I think I will start this round, first of all, by asking for the committee's indulgence. I may have to run up to the House at about 5 o'clock for a—I forgot how those are called—

Mr. Michael Harris: Private bills.

M^me^ France Gélinas: Private bills. Yes. If it comes in the middle of a rotation, I will beg your indulgence that I will make it up after. Sorry about that. But I'm good? I'm starting now.

The first thing I want to talk to you about is PET scanning—

Le Vice-Président (M. Michael Mantha): Excusez-moi, madame Gélinas : Does the committee agree with permitting Madame Gélinas to have her time roll over to her next round? Do I hear anybody opposed? C'est bon, madame Gélinas. Vous pouvez continuer.

M^me^ France Gélinas: Merci. It may not come, but there you go.

PET scans: How can I find out how much money was spent in Ontario on PET scans? Do we keep track of how many are done, how many per condition and per PET scan locations? Let's start with that.

Hon. Eric Hoskins: We're endeavouring to get some information for you right now.

M^me^ France Gélinas: I can see action behind you.

Dr. Bob Bell: Madame Gélinas, I can say—

The Vice-Chair (Mr. Michael Mantha): Can you introduce yourself for the record, please?

Dr. Bob Bell: Deputy Minister Bob Bell. I can say that we do fund these on a per case basis. There is an allocation made to the Ontario PET centres each year based on their historical performance, and that's trued up at the end of the year. We have a per case funding formula that we provide for PET scans.

M^me^ France Gélinas: This funding formula: Has it stayed the same since we started insuring PET scans in 2008 or does it change from year to year? And if it has changed, on what metrics does the change come?

Hon. Eric Hoskins: Hopefully, we've got the answer on that for you. I can add that we do over 11,000 PET scans in the province each year in total.

M^me^ France Gélinas: Is this because the demand has stayed at 11,000 or because the allocation has been 11,000?

Dr. Bob Bell: PET scanning in Ontario has been driven in a very interesting way by evidence developed by Cancer Care Ontario. As you know, in many jurisdictions of the world—PET scanners are available on every corner in the United States, for example, whereas Ontario has taken a very evidence-based approach, where Cancer Care Ontario has determined, for example, the initial indication for PET scanning related to assessment of nodes in the mediastinum in patients who had primary lung cancer. There was evidence to suggest that PET scanning was a very effective way of determining whether they were candidates for surgery, so that was an indication that was approved for PET scanning.

Each one of the indications—for example, for staging lymphoma and for staging patients who have recurrent thyroid cancer—has been approved in advance. The only way you get access to a publicly funded PET scan in Ontario is to have one of these evidence-based indications for a PET scan being undertaken.

M^me^ France Gélinas: Okay. I think I already knew this. The part I'm interested in is knowing—so you told

me there are about 11,000 PET scans done each year. Is this because there were 11,000 that were requested, or is it because the allocations to the PET scan centres amounted to 11,000?

Dr. Bob Bell: There were 11,000 patients who, based on the evidence related to their condition, qualified for a PET scan. That number has increased because the indications have increased.

Hon. Eric Hoskins: If I interpret that correctly, it's based on demand, provided that the demand for the PET scan falls within the recommended clinical indications.

M^me^ France Gélinas: Do you expect new clinical indications to come online shortly?

Dr. Bob Bell: The indications are reviewed regularly by the Program in Evidence-Based Care—

Hon. Eric Hoskins: And the PET Steering Committee, right?

Dr. Bob Bell: —and the PET Steering Committee that has been developed by that process.

Every year, they're updated. New evidence comes on board and new indications are added. We anticipate that, generally speaking, indications are not removed, so the number of PET scans undertaken in the province will probably expand year by year.

M^me^ France Gélinas: As you know, I have been very interested in having equity of access to PET scans. You know that my area, the northeast, did not have access. We have a plan in place to bring access. Although I would like it to be faster, at least it's there, and I'm happy with this, and I thank you for that.

There is another area of our province, in and around Windsor, that is about to lose their PET scans. It is a private clinic out there that provides PET scans. They are having technical issues with an aging PET scanner. I was wondering, how does the issue of equity of access come into the decision-making within the ministry?

Hon. Eric Hoskins: I'm sorry. We were just coming to an answer for—

M^me^ France Gélinas: The issue of equity of access.

Hon. Eric Hoskins: Yes. Again, we have a PET Steering Committee, which, as was referenced—I think I did, just several moments ago—is charged with the responsibility for establishing what those clinical indications would be for eligibility under OHIP funding. They're also responsible for that equity issue that you've referenced, and the siting of PET scanners, of which we have more than—is it a dozen or 14, somewhere in that range?—across the province.

Interjection.

Hon. Eric Hoskins: How many?

Interjection: There are 13.

Hon. Eric Hoskins: It's 13 currently, including the one in Windsor, which, I believe—am I correct that that's the one that's sort of parked there, if you will?

Dr. Bob Bell: Yes.

Hon. Eric Hoskins: I suspect, if it isn't already under consideration by the committee, this is something that the committee would look at, if there was a suggestion or the possibility that the one sited—yes.

It says "speaking remarks," and I'm going to speak them.

There is, as you've referenced, an independent health facility licensed to provide PET services in Windsor. It has submitted a funding request to the ministry, both base funding as well as a funding request for a new PET scanner, and the ministry is currently reviewing this funding request.

It's important to emphasize, in reference to their capital ask, that capital funding for PET scanners, as you know, for Sudbury, from that experience as well, is not provided by the ministry either in hospitals or in independent health facilities.

M^me^ France Gélinas: The part I don't understand is that I was very happy when you made the announcement that Sudbury would be getting $1.6 million a year—

Hon. Eric Hoskins: In operating.

M^me^ France Gélinas: Operating. What's the difference between the $1.6 million a year operating for Sudbury and this cost per scan that, Deputy, you were referring to? What are the total amounts?

Dr. Bob Bell: As I remember, in the Sudbury situation, there were about 800 patients who were being treated or being investigated in Toronto and other sites with PET. The sense was that that funding envelope plus some incremental funding could be transferred to Sudbury. That was the sense of what that would be, providing access to people in Sudbury.

Hon. Eric Hoskins: Just to clarify, I think that number is significantly lower than the 750, but that's what is anticipated that a new PET scanner—by increasing the equity and the accessibility as well, but also with projections going forward that it's anticipated to serve that number of patients on an annual basis.

M^me^ France Gélinas: Okay. Is anybody going to be able to give me the amount of money that we have spent this year and in the previous year on both operational funding and cost recovery per scan on PET scans in Ontario?

Hon. Eric Hoskins: We'll certainly look into that.

Dr. Bob Bell: So the other aspect that I was reminded of is that, just in terms of access, if somebody is turned down, if somebody is referred for a PET scan and deemed not to be appropriate for the approved conditions, there is also an adjudication process, an appeal process, that their physician can refer to.

M^me^ France Gélinas: For exceptional access, yes.

Dr. Bob Bell: Exactly.

M^me^ France Gélinas: I'm aware of how it works. What I don't know is how much money we have spent on this. Is the answer to how much money coming or is this something that—

Dr. Bob Bell: I don't believe we have it here. Just so I'm clear, you would like to know the total amount of money we spent in the province, the amount per case, which does vary depending on the indication a little bit, and also the amount that has been spent for Sudbury patients? Was that it?

M^me^ France Gélinas: No, I already have that.

Dr. Bob Bell: Okay.

M^me^ France Gélinas: I'm more interested as to how much of the Ministry of Health budget is spent on PET scans, either through the exceptional access or through the indication, and if it's the amount per scan, what is that amount and what does the total look like.

Hon. Eric Hoskins: We're going to look into that. I understand exactly.

And on the access and equity thing, if you'll just allow me really briefly to say that this is one of the areas where—and obviously geographic access is critically important, but also in terms of wait times. I think that this was certainly, I believe, the case a year ago, that the wait times are actually exceedingly short for our PET scanners right across the province and I think we've got a target of two weeks for all of the scans. I think there's virtually no wait-list and that individuals can get a scan at all of them, I believe, within a two-week period.

M^me^ France Gélinas: I wouldn't mind if you could check this because I hear that the wait-list in London has started to grow.

Hon. Eric Hoskins: We will.

M^me^ France Gélinas: If you could check, first of all, if we keep track of wait times for PET and if we do—if we set a target of two weeks, that's wonderful; I think that's pretty excellent care—where do we meet that target of two weeks and where do we not meet that target.

Hon. Eric Hoskins: Yes, I'll look into that for you.

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

The next question doesn't have as much of a follow-the-money aspect but I wanted to put it on the record. We've had issues with traditional medicine practitioners. Basically, about 1,000 of them never registered with their college, took their college to court, lost their battle in court and now we have this group that has formed an association of about 1,000 traditional medicine practitioners who still are not covered by the college. Is there a plan to solve this issue?

1610

Dr. Bob Bell: Assistant Deputy Minister Denise Cole, who the committee has met before, has some answers to this.

M^me^ France Gélinas: Thank you.

Ms. Denise Cole: Denise Cole, assistant deputy minister, health workforce planning and regulatory affairs division within the Ministry of Health.

Madame Gélinas, I would say about three or four weeks ago we were approached by the legal entity that has been working with the group of traditional Chinese medicine practitioners who have not registered with the college. Given the history and their lack of success in the courts, they would like to meet with me to figure out what a path forward could be because they recognize that they need to get on with it. So that meeting—I don't have the date at the top of my head, but I will be meeting with them in the next few weeks.

M^me^ France Gélinas: I think it's tomorrow.

Ms. Denise Cole: Is it? Thank you. I haven't looked at my schedule for tomorrow yet.

M^me^ France Gélinas: No worries.

Now that we have a college and the college has responsibilities that are sort of arm's-length from the government, is there really something that the government can do, given that there's a college and they've put those criteria in place?

Ms. Denise Cole: As you'd know, under the RHPA, the minister does have certain powers and things that he can direct. At this stage of the game, I haven't had the conversation with those groups as of yet. In fact, I've not met with them since I've been in the role for the last 18 months. I'm encouraged that they were the ones who reached out to us.

At this point in time, I'm in listening mode. We'd be encouraging them to work more co-operatively with the college than they have been to date. I'm someone who is a firm believer that when two parties are willing, it is possible to find common ground. Hopefully them coming to the table is around accepting and acknowledging the role of the college as the self-regulating, governing body and being prepared to work co-operatively.

M^me^ France Gélinas: I don't know if you're the right person to ask, but I will ask you, and maybe somebody within the corporate memory could remember. Was there ever a time when other new professionals came online, or a new college came online, where an extension of the grandfathering was done?

By memory, I sort of remember that when the nurse practitioners came on, the government ended up doing an extension of the grandfathering. Does anybody remember anything of the sort, or is it really up to the college and not up to the ministry?

Ms. Denise Cole: I don't know the answer to that in terms of the other professions that were done. I can get the answer for you, but that is something that we would look to the governing body to come to us with a recommendation on, as to whether or not it would be prudent to grant an extension of the grandfathering.

Le Vice-Président (M. Michael Mantha): Madame Gélinas, il te reste quatre minutes.

M^me^ France Gélinas: When you say "governing body," you mean the college?

Ms. Denise Cole: The council, the college.

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

My next question is to the associate minister. Do you have any plans to start to report the staffing information of long-term-care homes either on the Ministry of Health public website or otherwise? It was a promise that was made—not by you, but by the former minister—that would allow people to know the staffing information from the different long-term-care homes before they make their choice. Are you going to follow through with that promise?

Hon. Dipika Damerla: Before I address that specific issue, I just wanted to say that transparency is something that this government is obviously very proud of, our work around that—

The Vice-Chair (Mr. Michael Mantha): Associate Minister, can you come closer to your microphone?

Hon. Dipika Damerla: Oh yes, of course. One of the things that I was pleasantly surprised to learn is that Ontario is probably the only province in Canada that actually reports the results of all of the inspections that we do publicly—and I know that you're aware of that. There's a lot of information that is available for families, parents and potential residents to make an informed choice about a long-term-care home.

M^me^ France Gélinas: But specifically, I'm interested in reporting on the staffing information of different long-term-care homes. That's a promise that has been made, and it is in line with the transparency that has been increasing for the good of everybody, but this one is specifically with staff. It's a promise that was made and it's not there yet.

Hon. Dipika Damerla: We'll see if we can get back to you on that.

M^me^ France Gélinas: Okay. But right now, nobody is working sharing those?

Hon. Dipika Damerla: I think it would be best if we got back to you on that.

M^me^ France Gélinas: Okay. Would you know—

Interjection.

Hon. Dipika Damerla: Deputy, would you want to add anything?

Dr. Bob Bell: The only thing that I would say is that long-term-care homes under the act are required to have a written staffing plan for each patient individually. To describe a staffing plan that was for the average patient within a long-term-care home might not have much sense. There is no universal plan for a universal patient. I'm not even sure how we would undertake that.

M^me^ France Gélinas: When the promise was made, it was really to show that different homes had different staffing models. It was not a question of how many hours a patient would get, but it was really the staffing models that were used by the different homes at the time that the promise was made. So it would be in the number of staff per home or units or any other.

Hon. Dipika Damerla: If I can just say, we've said that we'll try to look into that, but I think it's really important to note that information in the absence of context is not as meaningful. As we go and try to give information, whether it's staffing levels or anything, it has to be in the larger context of the whole number of other—I'm just thinking this through, but a home could have 10 people and another home could have 11 staff, but then the number of residents matters. All of that data has to be in the context. Otherwise, it's not as meaningful.

I think it's a complicated issue, but what I can say is that one of the things I'm committed to and I know this government is committed to is providing as much information as we can to Ontarians to be able to make an informed decision about their preferred long-term-care home. I really want to take the opportunity to talk about some of the things that we do, including the inspection reports. Health Quality Ontario, of course, reports by long-term care on seven indices publicly. There's a lot of information already available that is very meaningful in terms of allowing loved ones and the resident to make that decision.

Le Vice-Président (M. Michael Mantha): Merci, madame Damerla. Merci, madame Gélinas. On va passer la parole à M. Thibeault.

Mr. Glenn Thibeault: Merci, monsieur le Président. Again, welcome to the ministers. It's great to see you both here again today. It seems like we see each other every day. Deputy Minister, it's also great to see you and all the great staff here, once again answering all of our questions when it comes to estimates. I know we're probably into hour 12 out of 15, with a few hours left to go. It's been pretty impressive to hear the answers that you've been able to provide. We're looking at—what, $52 billion is what we're spending on health care this year, $52 billion? That's quite an investment in terms of the funds that we're putting in as a government to ensure that we have a great health care system here in our great province of Ontario.

I'm going to talk a little bit about the health system funding reform, which you've spoken about, Minister Hoskins, quite a bit. I think it was about five years ago that Ontario started to shift its focus of the health care system away from a system that I think was always known to be a provider-focused system to a system that now revolves around the person, which is so key.

I know the Ministry of Health and Long-Term Care has worked hand in hand with health care partners. I can talk about many in Sudbury, but I know it's right across our great province. You've worked with them to move to a global funding model, towards a more transparent, evidence-based model, I believe, where funding is tied directly to the quality of care that is needed and provided.

1620

If we look to our 2016 budget, as part of the budget, when we're looking at the hospital measures on that, your ministry and the government of Ontario are proposing to invest more than $345 million in all publicly funded hospitals. I think that will include a 1% increase to the base funding to make sure that we can provide better patient access to high-quality health care services.

I think it's important to highlight that these investments in hospitals that are in the 2016 budget are targeted increases and—correct me if I'm wrong—they're targeted increases to access for patients. And we're looking at this to work hand in hand—or hand in glove, almost—with our Patients First action plan and that commitment to provide faster access to the right care, the right time and those types of things.

If we look at that and consider all of that in conjunction with what our hospitals are going to receive, we've got a 1% increase to their general hospital service delivery portion—I think that's something that we need to highlight because that represents an investment of $60 million in our hospitals just on that piece in their general hospital service delivery portion—and an increase in funding to our hospitals by an additional $50 million through the health-based allocation model. That's something that was important for me, as I say every time we

talk about it, with the cane and the crutches that I had for a while. So $50 million to improve access to wait times for hospital services, including additional procedures such as hip replacements, knee arthroscopies, cataract surgeries and knee replacements.

While I didn't have a knee replacement, Deputy Minister Bell, I think you actually taught my surgeon, Dr. Saidi, at one point, or at least worked with him.

Hon. Eric Hoskins: Oh, he's in trouble.

Dr. Bob Bell: And despite that, you seem to have done extraordinarily well.

Mr. Glenn Thibeault: I'm a month ahead of schedule, so do you know what? I'll take it.

No matter what you say, I have nothing but positive things to say about Dr. Saidi, the work that's happening at Health Sciences North and the great services that are provided for people in Greater Sudbury and northeastern Ontario who come in and utilize these services. We have Dr. Robinson—I don't want to start rhyming them all off because I'll forget one or two and then I'll hear from them as well. But even prior to that, Dr. Dave Healey was just another great surgeon that we had in Sudbury who has moved on to other locations, but we miss him in Sudbury and it's something that Dr. Saidi stepped in to help replace.

Speaking of all of the great things that have been happening at Health Sciences North, I think it's important to highlight—and I know that my colleague from Nickel Belt mentioned PET scanners. We were able to announce together, Minister Hoskins and I, the PET scanner in Sudbury in December of this year. As I said, watch our community grow. I'm very pleased to say that I had a conversation with the Bruno family fundraising committee last week, and we've raised an additional $1 million since that time, so they're up at around $2.2 million. We still have a little bit of a ways to go, but I always have pride and know that we come from a great community that will do great things. I'm looking forward to making sure that we get that service up and running in Sudbury and for the entire northeast as soon as possible.

When you were there, Dr. Hoskins, one of the things that we were able to find time for in our busy schedule that day was to take a quick tour of the NEO Kids facility. I know that my community has worked with the LHIN and is moving forward with the LHIN on promoting NEO Kids and working now with the Ministry of Health to ensure that the 35,000 kids that access NEO Kids—that's about 100 visits a day that we see in northeastern Ontario at HSN, at NEO Kids. So it's something that is truly, truly needed in my community.

Right now at NEO Kids, we have six pediatricians. Dr. Sean Murray, if you know of Dr. Sean Murray—he and I go way back. We played hockey together. We went to public school together. He has been doing great work in our community in advocating for NEO Kids to make sure that our kids get the services they need in northeastern Ontario. But we have six pediatricians right now, and RNs, RPNs and one nurse practitioner based out of NEO Kids. We have speech and language pathologists, social workers, physiotherapists, psychologists and many specialty visits from other practising doctors throughout Ontario, which I guess goes back to that $52 billion that we talk about that we're investing in the province in health care. We can start to see that evident in these places like NEO Kids, but as we took that tour, I think it was maybe five or six beds at Health Sciences North, so it's something that I know I'm very supportive of trying to ensure that we get for our community. I'm sure you'll be hearing a lot more from me on that as we continue to move forward on it.

But when I'm jumping back to the health system funding reform, we've seen a transformation that is only going to be successful if our funding models reflect the government's priorities, and that is, I think, putting patients first and making evidence-based decisions on value and quality that help sustain the system for generations to come. I know this term is used often, which is you "think outside of the box" and look at other opportunities and look at different ways of doing things.

One of the things, while I have you and the deputy minister and your staff here, is I wanted to say thank you on behalf of the city of Greater Sudbury and my community for the funding to continue the community paramedic medicine pilot program. It's $100,000. When we talk about a $52-billion ministry, $100,000 is still a lot of money, and it's doing great work. The paramedics who are providing this program came and spoke to me about how we're able to actually go in and keep people in their homes and they don't have to divert back to the hospital. They were talking, and I wish I had the statistics—you might be able to have that—of how many people they were able to keep out of the hospital and how many people they are able to keep out of the health care system just by having this one community paramedic person go to these homes. It is doing fantastic work. I know yesterday, when you were here, we talked about how we've really helped our doctor supply in the province and those types of things, and that's great, but there are still a few people in northeastern Ontario and in my riding who don't necessarily have a family doctor. When they come out of the hospital, especially a senior, this program is providing great service to them. So thank you for that $100,000. It's doing great work in our community and it's going far. That's what I think of when we're looking at outside of the box, talking about putting patients first. Most people want to stay in their home.

I know once upon a time in this committee, in the 15 hours or 13 hours we've been here, we talked about my father—101 years old, right? He passed away last year. He was adamant that he was going to die in his own bed. Unfortunately, circumstances didn't have that happen. But the great PSWs, who do phenomenal work in our community, came by, and if the Jays were playing, service wasn't happening, because you can't interrupt a Jays game. That's something that my dad was pretty adamant about.

But we've done a great job, I think, as a government, of looking at combining many things that I know I'm

talking about, combining the introduction of the Excellent Care for All Act and the foundation of quality across the province, and now the HSFR, which has been bringing in positive impacts to the Ontario health system, so the procedures we're seeing and lower length of stays, which is critical.

One of the things that I've talked about when I have talked with David McNeil at HSN is that hospitals have seemed to change for no other reason than it's almost like they are becoming hotels, where people come in and then they're staying. They're not leaving. They've got to come in, get the care that they need and then leave. When we see the start of the older demographics that are happening, that's some of the issues that our hospital system and our hospitals are going to see. When we see that, having a health system funding reform, I think, is key, and having the Patients First program is key. So I think we're on the right track when it comes to this.

Looking at key elements of all of this, patients receiving certain procedures, I think, when they are seeing the lower lengths of stay and expanding access for available beds for other patients and improving the quality of life for patients by getting them to go home sooner—I know with my surgery, for example, not that I want to get into all the gory details, but they pretty much sawed my tibia right in half. I was home three days later. Do you want to comment on that?

1630

Dr. Bob Bell: He didn't cut it right in half. We didn't teach him that.

Mr. Glenn Thibeault: No, no, no. It's the easiest way for me to explain it, right? And I have donor bone in there, which my kids think is fantastic because they say I'm part zombie now. They think that's great. I can chase them around. Yes, it's the easiest way for me to explain my surgery.

Mr. John Fraser: Another animal.

Mr. Glenn Thibeault: Another animal, yes.

Trying to go back to where I was and get my train of thought to get to my question, I have to start all over again, Chair, I think, right from the beginning.

Interjections.

The Vice-Chair (Mr. Michael Mantha): You have this pattern of asking lengthy questions. But go ahead.

Mr. Glenn Thibeault: You know what? It's just the preamble, to make sure that we put in all of the important and relevant information about the great work that I think the government and the ministry are doing. It's a $52-billion budget, as I said, and creating how many new doctors and new nurses and so many things—it's just such great news that I have so much to say, and I know that I can get to my question.

How much time do I have left, by the way?

The Vice-Chair (Mr. Michael Mantha): You have one minute left.

Mr. Glenn Thibeault: How much?

The Vice-Chair (Mr. Michael Mantha): No, I'm kidding. You have seven minutes left.

Mr. Glenn Thibeault: Seven minutes left. Okay.

Going into the HSFR, health system funding reform: Minister, talking about patients receiving certain procedures, lower lengths of stays, expanding access for beds available for other patients, improving the quality of life for patients by making sure that they go home sooner—my wife won't say me being home any sooner was a benefit to her, because I was whiny a lot. But it was pretty sore. Anyway, we'll talk about that later.

In addition, too, we are seeing gains in efficiency advantages. The government's efforts, I think, in achieving a sustainable health care system are key in all of this, Minister.

Maybe you can outline and provide to this committee an overview of the work the ministry has done to ensure that our health system remains sustainable for future generations of Ontarians as we move forward.

With that, I'll now hand the floor over to you to answer the question.

Hon. Eric Hoskins: Finally.

Mr. Glenn Thibeault: Finally.

Hon. Eric Hoskins: Thank you. I appreciate the question. On health system funding reform, in a nutshell, it really is focused on science and evidence outcomes and quality, and best practices.

It has different components to it in terms of how the funding flows and how that's calculated, hospital to hospital, but it has allowed us to focus on what's most important to patients, which is the outcome, like the outcome you described for your own procedure. If somebody requires cataract surgery, they are most concerned about what the outcome is going to be for them, right? Or if they need a hip or knee replacement, they're interested in the outcome.

I think we're in the twenties now of the number of quality-based procedures that we've developed under health system funding reform, and each of the quality-based procedures is focused on a specific activity, if you will, hip and knee replacement being good examples, or cataract surgery, as I mentioned. It has looked at every element imaginable, to ensure and to encourage a uniform delivery of that service across the province, based on the latest scientific evidence and practice, and looking at issues of cost as well, finding that efficiency in the delivery of the service and, in a sense, incenting and rewarding those hospitals that are able to demonstrate those highly positive outcomes.

Of course, there are variables in how the formula works that accommodate issues such as population growth—the number of patients that a hospital environment might see—as well as the measurement of other health needs and requirements in a community.

It's still early days, when you think about it. This is the fifth year of HSFR; it began in 2011-12. In that period of time—and I have to commend, appreciate and acknowledge the leadership across the province in the hospital environment, as well as through the OHA, that represents them, in working with us on this bold and, in many ways, challenging transformation to begin to look at everything we do, what we deliver and how we deliver

it in a hospital, in a slightly different way. But as you've referenced as well, we are beginning to see, through independent review and independent sources, the improvements, a higher quality of care and better outcomes that are a result of the changing formula for funding, which is more focused on quality and outcome.

You've referenced yourself that we've seen a reduction in the average length of stay for both surgical and medical admissions, which is important from an efficiency point of view, but it's most important from a patient experience perspective. We're seeing that what's remaining stable are the readmissions following being in hospital for medical or surgical procedures. People are spending a shorter period of time in hospital, but the outcomes are as good as or better than they were before. That's in the context of our hospitals on average—it varies a little bit around the province—seeing, overall and substantially, an increase in the number of patients.

This is work that the Institute for Clinical Evaluative Sciences has done to look at the impact of HSFR over the last four or five—we're now in year five, as I've mentioned. What's really interesting to me as well is that we're seeing definite and objective improvements in what would be referred to as nursing sensitive measures—incredibly important objective outcomes and improvements.

In this same period of time, we're seeing a reduction in the number of falls that are happening among patients in hospitals. We're seeing a reduction in the number of pressure sores that patients experience. We're seeing a reduction in the number of urinary tract infections that patients are impacted by in their hospital admission. We're seeing a reduction in cases of hospital-acquired pneumonia. Those indicators, as any front-line health care worker will tell you, are also exceptionally important because if we can't see those improvements or when they're prevalent, they can obviously lead to worse outcomes, and often significantly worse outcomes.

That combination that provides me with the assurance and the reassurance that we're on the right track is in those easier-to-measure, obvious, if you will—which are probably outputs more than outcomes in some respects, but measuring the length of stay in a hospital, for example. What we're finding is that there is no increase in hospital readmission rates, despite a shorter stay. But it's in those less obvious measurements of what happens when a patient is in hospital, which are critically important, where we're seeing those improvements.

I would have liked to take some credit for it, but it obviously pre-dates me as minister. Certainly, to Deb Matthews's credit and to the ministry's credit, obviously, and those stakeholders who worked with us to develop this approach—

The Vice-Chair (Mr. Michael Mantha): Thank you, Minister. Merci, monsieur Thibeault. We'll now pass the floor over to Mr. Harris for the official opposition.

Mr. Michael Harris: Good afternoon, Minister. On Monday, I asked you a question in the Legislature about St. Mary's hospital and specifically its regional cardiac care centre. Of course, St. Mary's is a world-class hospital with a regional cardiac care centre with world-class staff. I could spend the 20 minutes bragging about them, but I'm not going to do that.

Back in 2012, John Milloy made a commitment to deliver on an expansion of their cardiac care centre. As it stands right now, it remains the only one of the 11 full-service regional community hospitals in Ontario that is still waiting for an EP lab. It was promised in 2012. Minister, why, after four years, has it not been built?

1640

Hon. Eric Hoskins: All right. As you've referenced, the support that was publicly announced a number of years ago—and there's no question that the ministry and the LHIN are both supportive of the proposal from St. Mary's hospital for a new arrhythmia program. There is capacity planning currently under way by the Cardiac Care Network that will support this. Base operational dollars will be made available by the provincial programs branch in the ministry once the capital expansion is complete. That capital expansion is being recommended to proceed.

Mr. Michael Harris: We are now four years later. So you're telling me that the hospital submitted the proposal, the LHIN and the ministry have approved it, and now, CCN, the Cardiac Care Network, has also approved the capital and the operational dollars. What's left? What are we waiting for? Has the hospital received documentation from the CCN for this project to at least be tendered? We're at least 18 months away from seeing the facility open, so after its original promise, we're looking at five and a half, almost six, years before we get something done. Can you validate what you just said there, I suppose?

Hon. Eric Hoskins: This is, to some extent, a step-wise process. It's not that we have been inactive since 2012; that's the time—you're right—when our government communicated support in principle for a full arrhythmia program at St. Mary's. In that same year, we provided St. Mary's General Hospital with just under $1 million in base funding to support patients from the area that had received their implantable cardioverter defibrillator, or ICD, implant outside the region and then returned and received, at St. Mary's, support for monitoring and follow-up care. In 2013, St. Mary's, with government support, launched their implantable cardioverter defibrillator, or ICD, implant program, formally—

Mr. Michael Harris: No, I get it, and I don't want to cut you off, but I've got 20 minutes or less because my colleague wants time here as well. So walk me through the processes as to which—

Hon. Eric Hoskins: But that's part of the arrhythmia program, right? So what I'm trying to demonstrate is that it's a step-wise approach. In fact—

Mr. Michael Harris: But we need the capital to actually commence the construction process.

Hon. Eric Hoskins: So I'm telling you that the capital funding has been recommended to proceed.

Mr. Michael Harris: I understand that there is a significant process, and that's obvious. Now that that's

done, what will the next steps be, and how long, roughly, will the hospital have to wait until they get the paperwork from the CCN to begin the tendering process?

Hon. Eric Hoskins: I can't speak to the precise dates, but I should point out that it was in July of last year that the Cardiac Care Network reviewed the proposal for an advanced arrhythmia program at St. Mary's, including ablations. They reviewed it. I have the results of the review in front of me. But it really is important that, from 2012, when the government support in principle was provided, there have been significant activities that take place, part of which is that there's a requirement to mature and expand and develop the capacity, where you move—

Mr. Michael Harris: We're somewhat locked with the ability or the capacity, based on the room availability and the expansion that's required. Again, it's the last one of the 11 full-service regional cardiac hospitals that have been waiting for this lab. In fact, if you look at the CCN numbers posted, the provincial wait times for some cardiac procedures are the longest wait times in the province; in some cases, people are waiting 51 days, and, in Mississauga, eight or less, in some areas. So this has to be—

Hon. Eric Hoskins: That's why we're building the program.

Mr. Michael Harris: —a significant priority to make this happen.

Give me a rough idea. Maybe the deputy or other folks can help me understand. If, in July, they reviewed it, it's good to go and we're 18 months away, as you told us today, when can the people of Kitchener-Waterloo and St. Mary's expect to see some sort of documentation that will enable them to commence this project, not only the capital commitment but the operational commitment? I'm assuming one follows the other, right?

Hon. Eric Hoskins: Do you want to add to this, Deputy?

Dr. Bob Bell: Yes. Thanks, Mr. Harris.

As you know, the provision of electrophysiology services within an EPS catheterization suite is one of the most complex services that can be provided, from a capital basis, and, in order to get the capital approvals—in order to ensure the mechanical, electrical, the air handling etc. are there to protect patient safety—there is a fairly substantial approval process necessary on the capital side.

I can promise you that the discussions to enable the provision of those services and to develop that EPS suite are under way. There is often quite a bit of back and forth. Understanding what the base situation is in the hospital and understanding the improvements in air handling that are necessary often takes our staff quite a bit of time to make sure that patients are being provided with safe and effective care.

Those discussions are under way. You're absolutely right that once the capital facility is constructed, the operational dollars are there. As the minister says, operational dollars to the electrophysiology program are already flowing. The arrhythmia program starts off with implantable cardiac defibrillators. It then moves on as staff are recruited to EPS cardiac catheterization facilities. That program takes time.

Mr. Michael Harris: Yes, but fortunately we've had EP specialists recruited by the hospital. Unfortunately, they came and were waiting for this and have left. We were lucky enough to now have another one that started just this spring. My fear is that we could end up losing this individual if we don't have a clear commitment from your government.

We understand the discussions, but it's the paperwork that the hospital needs, and the community needs the acknowledgement. We've got the promise; we need the paperwork to allow us to get on with the capital.

When can people of Kitchener-Waterloo expect to see the commitment, the paperwork, that basically allows them to put the tender out to the street? When will that be? In the next month? Two months?

Dr. Bob Bell: You wouldn't want to have a tender out in the street before the base conditions are understood and the various elements leading to an appropriate RFP process are there. Those discussions are currently under way. That back and forth between the hospital and the capital branch is fully engaged. Until that understanding of base condition and exactly what modifications to the hospital are required—

Mr. Michael Harris: It's kind of the cart before the horse, I suppose, or what have you, but you know what? Again, Minister: When will the people of Kitchener-Waterloo receive the final—we've heard the promise. We're waiting for the paperwork. Can we expect to see that in the next 60 days? I hear the discussions and people are tired of hearing about the chit-chat when we heard the promise back in 2012.

How much time do I have left?

The Vice-Chair (Mr. Michael Mantha): You have 10 minutes.

Mr. Michael Harris: Ten minutes? Good. Maybe we'll get it out of them in 10 minutes.

Dr. Bob Bell: The paperwork can go out very readily once the description of the services required in the base hospital and exactly what's required for an EPS-ready cardiac catheterization suite is understood. It's not a problem with the paperwork, with respect, Mr. Harris. It's an understanding of what needs to be done and exactly what the characteristics of the RFP are. Do you need to replace the chiller in the base hospital? Do you need to replace the blower on the roof?

Mr. Michael Harris: Well, the chillers are relatively new there. But anyway, I guess there was a lot of planning but they need the green light and I don't think that they have seen any green light that they can move forward. I'm just wanting to get some commitment from you.

Dr. Bob Bell: Yes, and I don't mean to be argumentative, but with respect, the green light starts with a planning process between ensuring that the standards that define appropriate service delivery within capital struc-

tures are being met, the hospital understands that, the ministry understands the appropriate safety conditions, and appropriate terms of service will be provided. That then defines the RFP. So the paperwork is not an issue. It's not a bureaucratic process; it's a process of assuring quality in the development of new services within a hospital capital structure.

Mr. Michael Harris: And I'm confident they've got the capabilities there to perform the services. Again, it's one of the last full-service cardiac centres. You'll see the diagram that's posted, missing the EP suite.

You know what? I think I've made my point. You know what? We need to get on with this. We're 18 months away from opening a door and we've waited long enough. We're serving a million patients in the region of Waterloo out of St. Mary's. We're criss-crossing other LHINs to provide world-class cardiac care, and yet we're still waiting from an announcement that was made in 2012. This is unacceptable. I just ask that you make a commitment to deliver on a promise that was already made, especially in an area and at a hospital that has the expertise. They're ready to go; they just need an answer from you folks.

1650

I'll leave that one at that. I think I've been pretty clear on it. I'll look forward to seeing you. Minister, have you been to St. Mary's hospital?

Hon. Eric Hoskins: I have, thank you. But if you'll allow me—

Mr. Michael Harris: That's a yes? You have been to St. Mary's?

Hon. Eric Hoskins: If you'll allow, a lot has taken place since 2012, including substantial, multi-million-dollar investments by this government. As I mentioned, the Cardiac Care Network, as they're required to do, reviewed the specific proposal that was received last year. They reviewed it beginning in July of last year. I've indicated that we are recommending it to go ahead for the capital, as well as the operating that would flow afterwards.

Mr. Michael Harris: That's great. The promise in 2012—

Hon. Eric Hoskins: If you'll just allow me, it really is—and this is not specific to this particular activity. I just had a conversation with the three MPPs from Windsor, for example, about their proposal for a hospital—

The Vice-Chair (Mr. Michael Mantha): Eight minutes.

Hon. Eric Hoskins: It's critically important that both parties agree on precisely what comprises this project. That's the back-and-forth that we're having. It's not an issue of will we fund it or not or whether the capital is available or not; it's just reaching the conclusion so that we're actually providing the best quality of service that's needed.

Mr. Michael Harris: Well, I encourage you, and I know the hospital will make their folks available with your people to get this under way. The 2012 announcement took till 2015 to review.

Anyway, do you hear where I'm going with this?

Hon. Eric Hoskins: Yes, I do.

Mr. Michael Harris: And I hope to see you at St. Mary's hospital soon. I'm sure they'll have a ribbon and scissors ready for you whenever you get there.

Hon. Eric Hoskins: And you.

Mr. Michael Harris: On that, we just briefly touched on fiscal year-ends for hospitals. I asked you briefly if there will be hospitals that will, in fact, report a deficit this year, and I believe you did concur with that. I'm wondering if you can tell me how many hospitals across the province are likely in a deficit position and will, in fact, report a deficit this fiscal year.

Hon. Eric Hoskins: I don't believe that I did, at least—

Mr. Michael Harris: All right. Will there be hospitals—

Hon. Eric Hoskins: No, just as a point of clarification, I don't believe that I did indicate that there would be hospitals in a deficit position. I'm not sure whether we even have that information yet, at this point.

Mr. Michael Harris: The fiscal year ended March 31. Have there been any signals to the ministry from the LHINs that hospitals in the province are likely in a deficit position or will have sought permission to get a waiver for the last fiscal year?

Dr. Bob Bell: We've just received audited financial statements from all the hospitals and we're working on the consolidation on a provincial basis, so we would not have that information currently.

Mr. Michael Harris: So you have received audited statements. Are there any that have, in fact, provided audited statements that show a deficit?

Dr. Bob Bell: I don't have that information in front of me right now, but we could probably see if we could get that information.

Mr. Michael Harris: Have you been informed by staff that any hospitals have submitted deficit audited statements?

Dr. Bob Bell: I have not been informed by staff if that's the case.

Mr. Michael Harris: By any?

Dr. Bob Bell: At this point.

Mr. Michael Harris: We know that across the province there are some hospitals that, prior to their fiscal year-end, especially in the cardiac care end of things, performed additional procedures that maxed out their funded targets prematurely. We were given acknowledgement from the province that they would continue on with those procedures and that the government would cover the difference. How many hospitals in Ontario would have been in that position?

Hon. Eric Hoskins: I don't have knowledge of the specific number, but there are a number of procedures that are funded based on volume, as you've indicated.

Mr. Michael Harris: Do we have a list of those?

Hon. Eric Hoskins: We might have the answer for you.

Dr. Bob Bell: There are 19 hospitals receiving services that are volume-funded within comprehensive cardiac programs.

Mr. Michael Harris: So there are 19 facilities that will receive additional funding?

Dr. Bob Bell: Sorry, that's the total number of advanced cardiac centres that perform services that are volume-funded. That's the number. In terms of the number that received extra funding, I don't have that information in front of me.

Mr. Michael Harris: I guess my question is, what is the process through which a hospital gets approval to carry on with procedures and the ministry agrees to cover those? What is the process, then, by year-end, to cover that off?

Dr. Bob Bell: Maybe I could start and then turn it over to Assistant Deputy Minister Lynn Guerriero, who has responsibility for provincial programs, including Cardiac Care Network.

There are a variety of programs that are volume-funded that are estimated based on historical performance—

Mr. Michael Harris: Yes, I know.

Dr. Bob Bell: This gets trued up subsequently.

Mr. Michael Harris: I guess I'm curious: How many of those hospitals will report a deficit this year? Do you know? Do you have that information?

Dr. Bob Bell: In cardiac care?

Mr. Michael Harris: Just hospitals in general—audited statements of hospitals that will—

Dr. Bob Bell: But I have already mentioned that we have just received their audited financial statements. We're working on the consolidation of hospital accounts—

Mr. Michael Harris: Tell me what the process is. If a hospital has a shortfall, and if government has made a commitment to cover that shortfall, what are the processes by which they go about doing that?

Hon. Eric Hoskins: I think Lynn can speak to that.

Mr. Michael Harris: I'm just curious as to how that works.

Ms. Lynn Guerriero: Hi, it's Lynn Guerriero. I'm the assistant deputy minister for negotiations and accountability management.

I think I mentioned maybe last week, or a couple of weeks ago, that we did do a piece of work in 2015-16 with all of our cardiac centres with respect to some volume pressures that probably the vast majority of them were having with various procedures.

Throughout the year, there was a very transparent process where all facilities were engaged in conversations with the ministry and with Cardiac Care Network, where we did some work around how best to manage volumes to the best of everyone's ability within their facility.

We also did some work around transferring volumes between one facility and another, because sometimes certain hospitals had issues and others did not. We want people to get care closest to home and not necessarily be transferred to another hospital.

Mr. Michael Harris: How have you funded the delta, then, on some of those?

Ms. Lynn Guerriero: After we did the reallocation, and after we asked people to reforecast the volumes that they would be doing—they did tons of work with us, and the hospitals did a great job reforecasting—we made a commitment that if they could try to stick to those reforecast numbers, we would commit to paying for those volumes.

Mr. Michael Harris: Okay.

Ms. Lynn Guerriero: We have given hospitals up until the end of June to submit their volume data, so we actually don't have the data yet, with respect to which hospitals may or may not have gone over that amount. For those that do, we will fund those procedures. For hospitals that, even notwithstanding the tremendous work they did to try to manage their volumes, still went over in certain cases, we will pay for those volumes.

Mr. Michael Harris: What happens when a hospital has to file their year-end statements by tomorrow? Where does that funding gap come in?

Ms. Lynn Guerriero: I'm not sure how they're filing their year-end statements.

Mr. Michael Harris: How is that going to work?

Dr. Bob Bell: Do you want me to tell you, as a former CEO?

Mr. Michael Harris: Yes.

Dr. Bob Bell: You work with your external auditor. There are variances, there are footnotes, that are—generally speaking, the ministry is always considered to be good for its commitments—

Mr. Michael Harris: Have you issued letters to those folks?

Dr. Bob Bell: Generally speaking, there is a letter. I'm sure we provide it to these hospitals as to their estimates of what the funding allocation would be. They then true it up after financial year-end. The hospital demonstrates to the accountant that it has done the cases. They demonstrate, in the letter, that those cases will be paid for. They're included as proved revenues and achieved revenues within the fiscal year, and go into the—

Mr. Michael Harris: So those letters have gone out?

Dr. Bob Bell: They would have gone out.

Ms. Lynn Guerriero: We've been corresponding with hospitals about their projected volumes and the plan to move them around. Once we have final volumes in from hospitals, they will get letters that support that funding.

Mr. Michael Harris: By the end of the month?

Ms. Lynn Guerriero: When we get their volumes by the end of the month? I can't give you a date by which the letters will go out.

Mr. Michael Harris: For last fiscal year?

Ms. Lynn Guerriero: For 2015-16.

Dr. Bob Bell: But in terms of the audited financial statements, what will often happen is that we will have

sent a letter saying, "Here is a commitment to fund those cases." The hospital demonstrates to the auditor that the cases are accomplished and their achieved revenue is within the hospital's in-year accounts.

Mr. Michael Harris: Thanks, guys.

The Vice-Chair (Mr. Michael Mantha): Thank you, Dr. Bell. Thank you, Mr. Harris.

On va passer la parole à M[me] Gélinas.

M[me] France Gélinas: Because of what I see going on in the House, I will excuse myself and go do this private members' business and I will be right back. I'm really sorry to force out of a rotation, but I will be right back. Sorry about that.

Le Vice-Président (M. Michael Mantha): On va transférer la parole à M. Thibeault.

M. Glenn Thibeault: Non, je pense que c'est MPP Kiwala qui donne la présentation au comité.

The Vice-Chair (Mr. Michael Mantha): Ms. Kiwala?

M[me] Sophie Kiwala: Oui, je peux. Merci.

The Vice-Chair (Mr. Michael Mantha): Go ahead.

Ms. Sophie Kiwala: Thank you very much for the opportunity to be here. I just want to say thank you, as well, to you and your staff, the deputy minister and the associate minister. It's always a pleasure to have you here in estimates, and it's always a pleasure to hear from your staff as well. I know that you've got an absolutely smokin' ministry, and your staff—

Interjection.

1700

Ms. Sophie Kiwala: Not literally, of course, but your staff is amazing, and I just wanted to give that shout-out, because quite often they carry a large load on their plates and don't always get acknowledged for it. So thank you very much to your staff, as well.

I always do appreciate very much listening to your perspective on health and the changes that we're making. I really have been very inspired by the energy that you've brought forward to this ministry and your excitement, which is palpable, about the changes that we're making in health care. The Patients First changes, the whole concept of providing that wraparound care to patients and the whole notion of collaborating with all of the partners in the process are extremely important to creating the best possible outcomes, as I know you know, but I did just want to give you that shout-out.

I wanted to talk to you a little bit about public health. I do also, of course, want to give a shout-out to the public health unit in my riding of Kingston and the Islands. It won't be quite as lengthy of a shout-out—

Hon. Eric Hoskins: Please.

Ms. Sophie Kiwala: —and deviation from the question as has been evidenced around this table, but—

Interjection.

Ms. Sophie Kiwala: Yes.

The public health unit in Kingston and the Islands has been doing an absolutely awesome job. I truly respect their work. I appreciate that on-the-ground, close connectedness to the constituents of our riding. They have been doing some phenomenal things, including—and I'm just going to read off a few of the different programs that they are offering, which I'm sure you are familiar with: "Standard Size Your Drink," the whole notion of making sure you are being aware of what you're taking in, the amount of calories; I believe they're still doing travel vaccinations—I've had some travel vaccinations there before going to Africa in the past; the Stop Texting initiative; Healthy Smiles; and healthy choices and the focus on recreation centres.

But more specifically, there is an initiative that has been driven, in Kingston and the Islands public health unit—

Interjections.

Ms. Sophie Kiwala: I'm going to test you on this later.

Hon. Eric Hoskins: We're just so impressed with your delivery that we were just commenting—

Ms. Sophie Kiwala: Right. Okay. I just wanted to give a shout-out to the local unit for spearheading a national action plan on Lyme disease. Forty-two experts, physicians and researchers from across the country convened together in Kingston and the Islands. It was spearheaded by the associate officer of health, Dr. Kieran Moore, as well as the Chief Medical Officer of Health for Ontario, Dr. David Williams. So I'm very, very proud of that work. I did have the opportunity to address their conference on April 21. It was a two-day conference in Kingston—absolutely fantastic.

So feel free to elaborate on anything that we're doing on our own provincial action plan on Lyme disease, but specifically outside of that, I would like you to comment on the overall state of Ontarians' health and what you're doing to make Ontario the healthiest province in order to grow old, because we're all getting there, regretfully.

Hon. Eric Hoskins: At the same rate.

Thank you for that. You know that, apart from being a medical doctor, my specialty is actually public health, so this is an issue that's near and dear to my heart. You referenced Lyme, and I'm not going to go into it in detail other than to acknowledge and appreciate, on the record—your riding, Michael?

The Vice-Chair (Mr. Michael Mantha): Algoma–Manitoulin.

Hon. Eric Hoskins: —the member from Algoma–Manitoulin, Michael Mantha. Just this week, we had a meeting with some remarkable advocates and patients with very direct and challenging experiences with Lyme disease. I think we came to a very positive conclusion at that meeting, and thanks to Michael for actually making it happen. That conclusion was that Ontario has got a lot of work to do to catch up with the science, to listen to patients better when it comes to Lyme disease, to educate our physicians, and to give them the confidence so that they can receive and treat and support patients who may be or are experiencing Lyme disease so that they can do a better job at that. There are many components, from diagnosis and testing to treatment. It's an incredibly important issue.

I'm not going to talk any more in the remaining time because we do have the opportunity—we have our Chief Medical Officer of Health, Dr. David Williams, who you acknowledged yourself earlier. I think it's important that he be given the opportunity to speak, and for us to have the opportunity to hear from him as well with regard to what he sees as priorities in public health and the opportunities and some of the activities that are currently under way. Thank you, David.

Dr. David Williams: Mr. Chair, I'm Dr. David Williams, Chief Medical Officer of Health for Ontario.

Thank you for the question and interest in public health, and from the minister as well, and I'll talk about that in a moment. Yes, it was great to be out at Kingston and to work with Dr. Kieran Moore and Ian Gemmill, a long-term compatriot of mine, and the excellent work that he's done there over the years going back.

The question is a good one. It's one I'd love to spend all afternoon on, but I won't. I'll give you some highlights and spotlight a few things there that I think would be of interest to the members as well as to those here. I'm talking about the health of Ontarians. We've been talking a lot about some of the health systems, but let's talk about the health issues there and how to make Ontarians healthy and Ontario the healthiest place to be.

It's a great message to send out, whether it's encouraging people to get a flu shot, preventing HPV or human papillomavirus virus, not smoking, knowledge about blood pressure and hypertension or preventing injuries, and those are just a few of the things. But most of all, there's a focus around public health. When you're talking about keeping people healthy, we're talking about the pillars of public health. The three legs of the chair that we talk about are prevention, promotion and protection. These all work interactively and enable us to carry out action.

A difference with our public health programs as compared to hospital systems, where people enter voluntarily into the system—or involuntarily, because of emergency situations—is that we have to work with the public as citizens of the community. As such, we have to gain their trust. We have to have their confidence. We have to work with them for education and knowledge in all three pillars that we talked about. That adds an extra challenge.

Certainly, having the activity of our 36 health units, Kingston included, as well as our medical officers of health and the health units and staff is a great resource in Ontario that is a unique one across the country, being the only municipally funded public health entity, with, of course, large grants from the minister. This makes a dynamic combination of expertise and local connectivity to bring about that education and to work with the local citizens and with local municipalities to bring about the best result and ensure the health of Ontarians.

I'm going to talk about a couple of things now and I'm going to give you some recent examples on that. In the area of protection, we usually talk about protection and prevention. They're pretty close. One deals with immediate actions that would result in—some actions there that would be immediate effects, either mortality or morbidity. It requires action, either assertively through education materials or through acts and orders at times. Prevention is more about things that could happen in your future that you take steps to do, and I'll talk about promotion.

On the protection side, we mostly focus on food safety, water, and we talk about outbreaks and the management of that. As you recall, having being involved in the SARS outbreak of the past, those days, and through Operation Health Protection—that's why I'm talking about protection here—we've come a long way. We've done a number of things to put in place between the dynamic activities and the increased capacity and knowledge base of our local health units, our medical officers of health, our associate MOHs and their staff, combined with our IT systems such as the integrated public health information system, and also with Public Health Ontario, which was not there during SARS. During that time, we have greatly increased our capacity to deal with that. As such, Ontario is one of the leaders in undertaking and detecting some of these early outbreaks as soon as possible. Our laboratory in our public health agency is second only to NML, the national medical laboratory, in Winnipeg.

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I'll give you some recent examples of how that has worked. In April, we became aware of cases of hepatitis A in our communities. We started an investigation, trying to figure out the epidemiology. That means you do the testing, you map it out, you interview them all and go through that tendency of "What did you eat? What did you consume?" Through that process, we were able to identify that the source was a frozen berry product from one of the retailers called Costco. It was effective through all of eastern Canada, from Ontario on. Fourteen of the 16 cases were identified in Ontario.

We were the first to identify it through the epidemiology. We worked with our federal counterparts. We have a FIORP, which is a food investigation outbreak response plan. We worked with CFIA, the food inspection agency of the federal government, with PHAC, the Public Health Agency of Canada, with Health Canada, and with other health units and other provinces at the same time to bring about a response—and in this case, with the retailer. That means a lot of work to bring that and inform all the public on that and to do a timely response.

Over that time, we've now done some assessments. We're still reviewing the process. Just under 7,000 people were vaccinated in Ontario for hepatitis A, in conjunction with the health units and in conjunction with the retailer, which was a new endeavour of ours. As such, that brought about protection of our Ontario citizens, because hepatitis A, as you remember, is not the B one but the one where you get the jaundice and that. We usually talk about it at summer camps or places where they got it from food-borne outbreaks. It's passed orofecally on that basis there. As a result, it can spread through communities fairly quickly unless you curtail it

and control it. That's to protect especially children. It can move through subclinically very extensively before you pick it up.

So there's an example of where the dynamic interaction kept Ontarians healthy and protected, especially the vulnerable ones in our community who have immunocompromised situations, the very young and the very old. More recently, again, in Ontario, we have been trying to detect one of our old friends, listeria, or Listeria monocytogenes, which causes gastroenteritis. Most people can throw it off fairly quickly, but for the vulnerable—that means the immunocompromised, especially the elderly and pregnant patients—it can cause severe sequelae and, in some cases, death. We started finding clusters of cases and we tried to search the source in a group. Then, six weeks later, we had another cluster of over 20 in each group. We were trying to investigate.

As a result, we have identified now—and we're trying to get a confirmation from CFIA—that, unlike what we had thought, that it was originally related to some salad combinations, it was actually related to positive samples in chocolate milk. We are trying to investigate that now with a certain producer in Ontario. They have curtailed their production of that. The surprising thing to us is that you would think chocolate milk was consumed by kids. In the main cases that we're finding, most of them were over 75, because a lot of seniors are using it for a supplement and a lot of our LTCs are using it for that as well. That meant we had to move urgently to ask our long-term-care facilities to check their fridges and materials, remove that product and the recall materials from all those sites, and to alert them quickly because it would have severe consequences potentially in the health of those seniors and potentially death too, because they have an immune status limitation.

So that gives you the dynamic of how the interface between the laboratory, which is doing very sophisticated lab testing now—we call it fingerprinting. There's a fancy term called PFGE—it's like DNA in other cases—that is so specific that we can map cases that are spread throughout the province. That gives us much more urgent alert. Now we have whole-gene sequencing as well. That sophistication of the lab, combined with the local epidemiological follow-up of the health units and with the ministry counterparts, means that we have a very rapid response to protect our citizens in Ontario. They always say, "It seems like all the outbreaks start in Ontario." I think it's because our surveillance is that sophisticated. Can it be made better? Always. We're always working at making it better. So there are some examples of the protection side.

Le Vice-Président (M. Michael Mantha): Madame Kiwala, il vous reste cinq minutes.

M^me^ Sophie Kiwala: C'est dommage.

Dr. David Williams: Yes.

On the prevention side, we have a lot of things related to sanitation, rabies, screening new citizens for tuberculosis and aspects there. One of the key things that we've focused on all the time in prevention is our vaccination programs, and it's the one that has had the greatest impact.

As you'll be aware, back at the end of April, I did table my report to the Legislature, Vaccines: The Best Medicine. You all received a copy in English and in French. In that, we were trying to not only talk about how much that has impacted and dropped the amount of morbidity and mortality, especially among our children in Ontario, with huge gains—also to engage the public, because we need to. It's the public's vaccination program. We've been dealing with more hesitancy among the public. How do we engage in that dialogue with a younger parenting group? As a result, I also put out accompanying—this is my version of the last yellow card. I know the minister, if he had a chance, would like to tear up the yellow card. Don't tear this one up.

Hon. Eric Hoskins: No, I'm not going to tear it up.

Dr. David Williams: This was a method to get out the information in a more graphic form that's user-friendly. It has QR codes for parents who can quickly click on them, get vaccine schedules and access it. This is just my product. We're hoping it might be allowed more. I have brought copies, so if members would like it—en français aussi—for their benefit. I'll leave these here with the Clerk, if you'd like to have a copy for yourself. I think you'll find it's more reader-friendly and more for the public to get the public engaged and taking part.

To give you some ideas of examples and impacts, back four or five years ago, we introduced a number of new vaccines that I was brought in on. One was rotavirus. Rotavirus is an infectious disease that causes gastroenteritis in children, especially under the age of five years, and it's particularly difficult in one to two years of age. It causes up to 70% to have to get hospitalized and has effects on that. We've tried evaluating our first three years of our program going forward, and already we've seen in over the age of 12 months a 79% reduction in hospitalization rates in that whole cohort. That's just the early findings. This backs up the value of that, and you can even calculate the cost or the expenses for the hospitalizations, let alone the personal impact on young parents with their child getting severely ill in this situation. So there's another new program that we introduced. We're already seeing the benefits of that, and that's on a go-forward basis.

Furthermore, you've seen some changes announced in Immunization 2020. You've already heard some presentations on that. Talking about the issue of vaccination in our schools, we've added more to our Immunization of School Pupils Act, adding to our other previous vaccines a requirement to have varicella and pertussis, or whooping cough, as well as with invasive meningococcal disease at the older age group, which we're doing in our school vaccination programs.

The thing about the Immunization of School Pupils Act is that it is a requirement to have documentation of records. We want the public to participate in that. They supply the records to the local medical officer of health, so he or she can have a record of who they are. That

means that at the time of an outbreak—because among that group, there are medically vulnerable children who cannot take the vaccine because of medical reasons, or they're immunocompromised. If we know there's an outbreak occurring, we know to exclude them during that outbreak, to protect them. So we have to know who is immunized and who is not. Included in that, there's a group called conscious objectors. That group seems to be growing. Some are long-time anti-vaccine people, but a lot of the time, more now, it's people doing it because they're busy, they haven't got the time to think much about it and it just doesn't seem necessary at that time. As a result, as the minister, Dr. Hoskins, announced under 2020, we've added in there an education component because we want to have that opportunity, rather than just going to a notary or someone and signing a form and handing it in, to sit down as you would with any doctor-patient relationship and have that session to discuss: What are your reasons? What do you need to know? Is it an informed consent, or, in this case, dis-consent to not take part? Do you understand the consequences, the sequelae?

I've had that opportunity, in my own time in Thunder Bay, when some came in adamantly opposed and were expecting an argument or basically a lecture, and we had a discussion. They found that very helpful and they went back and reflected, and they came back and had their child vaccinated. We hope to have that opportunity to acquire that and to understand what the reasons are why they're not getting vaccinated, because that is in the social discourse, if you've listened to the radio for the last two years around the MMR, the societal responsibilities. It's that kind of discussion that I applaud because it's the public taking ownership and saying, "This is our vaccine program. This is something we feel proud of."

The Vice-Chair (Mr. Michael Mantha): On that note, thank you, Dr. Williams. Merci, madame Kiwala. On passe la parole à M^me^ Gélinas.

M^me^ France Gélinas: Again, thank you so much for accommodating my need to run into the House for a very quick period of time.

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Because the Chief Medical Officer of Health was there, I thought maybe it would be a good time to ask, but we'll see if one of you wants to answer the question. We all know that recreational cannabis is around the corner. It's been anticipated by hundreds of thousands of Ontarians who cannot wait until this becomes available in Ontario. I was wondering if there's any money in the budget for an educational campaign and if there's any work being done to look at what will be the age, what will be the distribution system, what will be the hours of sale, but most importantly, how much money has been put aside for education campaigns for Ontarians?

Hon. Dipika Damerla: I'm actually happy to answer that. Thank you for the question. Indeed, work has started. It's an inter-ministry effort, so it's not just the Ministry of Health. As you can imagine, a number of ministries, from the Ministry of Finance, the Ministry of Community Safety and Correctional Services, the AG's office—it's multi-ministry and across government. Work has started on all of the issues that you have highlighted.

But it's really, really important to put into context that until the feds actually move towards providing us with a framework—it's the federal framework that will influence exactly our level of involvement and jurisdiction. At this point, it's not clear just how far the feds will go in regulating and providing the framework.

What I can say is that Ontario is doing what it needs to do to be ready, if and when the federal government does decide to legalize medical marijuana. As you're also aware, a federal-provincial table has also been struck by the federal minister. So work is going on both at the Ontario government level and between the federal government and the Ontario government.

M^me^ France Gélinas: My question was, how much money is in the budget for education for this new policy coming forward?

Dr. Bob Bell: Thank you. Could I ask our ADM of public health and health promotion, Roselle Martino, to speak to this? Because there is currently an inter-ministerial approach to this. Our role in this, really, Madame Gélinas, is a harm reduction and education approach that I think it would be useful for ADM Martino to speak to.

If you could introduce yourself again, Roselle.

Ms. Roselle Martino: Yes. I'm Roselle Martino. I'm the ADM for the population and public health division, Ministry of Health. In addition to what the minister has said, there are actually a number of ministries involved in this. We don't have an allocation in the budget for this initiative, Madame Gélinas, but we are currently having those discussions that are being informed, obviously, by the federal discussions that are taking place, and with other key ministries across government as well to try to get a sense of what the policy framework would be around the legalization of marijuana and then what the various costing of elements would be.

As the deputy said, the government recognizes—and I believe both ministers would support this as well—the importance of the harm reduction and prevention piece, and awareness, should this become legalized. Those elements are fundamental in terms of public education and awareness. We are doing that internal discussion and costing presently.

M^me^ France Gélinas: Thank you. Because it's close to the last rotation, I will be jumping around from file to file.

My next question: Do we keep track of complaints that have to do specifically with FHTs and FHOs? I have a number of them: family health organizations, alternate payment plans for physicians; I'm sure you're fully aware of this. There have been a number of complaints against them that people have a hard time resolving themselves. Some of them have reached out to your ministry and were basically told that a patient complaint is the responsibility of—

Interruption.

The Vice-Chair (Mr. Michael Mantha): Excuse me, Madame Gélinas. Whoever has that phone, can you please turn it off or take it outside? Thank you.

M^me^ France Gélinas: Do we keep track of the number of complaints and who handles that at the local level? As I said, your ministry responded to this particular constituent that a patient's complaint is the responsibility of the FHT if it relates to organizational activities. But I will start with the FHO. So it's just the payment. They still do have responsibility for extended hours and for access. If they don't meet those right now, do we keep track of how many, and what can patients do?

Dr. Bob Bell: At present, if we're talking about family health organizations, or FHOs, where there is no executive director and there is no administrative structure—it's simply a group of physicians who are grouped together in a compensation arrangement, and oftentimes they have a call-coverage situation—there is no formal complaint process that leads to the ministry having the ability to tabulate the number of concerns.

There is, of course, a professional misconduct process. There is the professional competency aspect to any physician practising in the province, and there are complaint lines for those aspects at the College of Physicians and Surgeons as—

M^me^ France Gélinas: It has to do with hours of care, like they're supposed to be open at night; they're not. They're supposed to be on pagers; they're not.

Dr. Bob Bell: Certainly that's an important part of the Patients First strategy that the minister tabled. But at the present time, there are aspects related to hours of service that could potentially fall into the category of professional misconduct. That would be extremely unusual. Of course, if there are complaints related to professional misconduct, the CPSO—

M^me^ France Gélinas: No, we've already ruled out the CPSO. The CPSO says that this is not misconduct; it's that they're not honouring their contract to provide extended hours and to be on call.

Hon. Eric Hoskins: That's one of the issues that we're aiming to address through the Patients First Act. Giving our LHINs authority and responsibility over primary care planning as well as performance and developing a set of indicators—including the one that you've referenced—that are meaningful to patients will give us the ability to work with our primary care providers, not only to measure that and track it but also remediate it where required. I think I've referenced it before. It's one of those very important indicators—the issue of access. I like to define that there are outputs and outcomes. This is more of a measurable output, although you can certainly imagine that it can potentially impact quality of care and outcomes. It's an important measurement.

M^me^ France Gélinas: Okay. In the bill right now, if they are an agency, if there's an FHT, a nurse-practitioner-led clinic and an AHAC, they will be under the financing and monitoring of the LHINs, but the FHO won't be. They will continue to be your responsibility. The LHINs will have oversight, but through your ministry, they're not allowed to do anything right now, and they still won't be allowed to do anything after the bill goes through.

Dr. Bob Bell: Actually, we spent a couple of hours this afternoon talking to the Ontario Medical Association about this very issue. We've talked extensively to the Ontario College of Family Physicians and to AFHTO, the Association of Family Health Teams of Ontario. As well, I was earlier today talking to the Association of Ontario Health Centres about this very issue.

As you know, in the legislation, when it comes to primary care contracts—not fee-for-service—the LHINs will have the power of agency for the ministry, not negotiating terms of work or compensation; that remains the representation rights agreement for primary care and all physicians that the OMA has, according to our agreement. However, for issues like you're describing—levels of service, hours of operation and, crucially, the issue of access—this is something that we anticipate the LHINs' sub-regions will closely monitor. They will have not only administrative capability on behalf of the ministry but also, importantly, they will have primary care thought leaders. This is what we learned from the Price-Baker report. This is not an issue that only patients want to see enhanced; this is something that primary care providers crucially want to see enhanced because 50% of patients in primary care models across the province are getting excellent access. It's the 50% providing great access that are saying, "How do we improve performance?" That's what the Patients First bill is designed to speak to.

M^me^ France Gélinas: So right now we are not counting how many of those, but once the bill passes and the LHINs have responsibility, will you be keeping track of how many complaints you get specifically, let's say, against the FHOs? Not against the agencies—we already know that. It's really against the fee-for-service and the FHOs and the alternate payment models that are not tied to agencies and to interdisciplinary care that I'm interested about.

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Hon. Eric Hoskins: We'd certainly have opportunity for that.

M^me^ France Gélinas: Opportunity for that. Okay.

Hon. Eric Hoskins: I've got some of the requested information in terms of PET scanners, if you want me to provide that briefly.

M^me^ France Gélinas: Oh, thank you. Yes, please.

Hon. Eric Hoskins: You asked for the province-wide expenditure, in the first instance, for PET scans. I think we're up to about 12,000 annually, in the most recent year at least. The actual cost of the scans in 2015-16 was $11.6 million, province-wide.

M^me^ France Gélinas: Can I have it for previous years? How much did we spend?

Hon. Eric Hoskins: I do not have that, but you can imagine—and I've also got the cost per scan in terms of the professional fee, if you're interested in that.

M^me^ France Gélinas: Yes, please.

Hon. Eric Hoskins: It's $237.50 per scan as a professional fee. If I understand this correctly, the compensation or remuneration is $450 per scan if it's with respect to a diagnosis of cancer. If it's a cardiac-related scan, the compensation is $750 per scan. Now, there may be some—I think that's fine.

The last thing I had was I just wanted to clarify that I had suggested that the wait times are typically less than two weeks, or 10 business days. In fact, that has been and is the case, that Ontario has not exceeded the two-week wait times to date. In fact, our monthly median wait time for the last five years has ranged from three to eight business days.

M^me^ France Gélinas: Thank you. All right. I'm sort of jumping a little bit all over the place. Do we keep track of code white in hospitals?

Interjection: Of what, sorry?

M^me^ France Gélinas: Code white.

Dr. Bob Bell: Code white—violence. Not to the best of my knowledge. I don't believe we have aggregated the information regarding code white, no. We would not have.

M^me^ France Gélinas: No?

Dr. Bob Bell: Code white may turn out to be a very trivial episode, or it could be something of more significance. Certainly, we keep track of incidents that result in injury to a staff member or injury to a patient. If there is violence that results in injury, we would have information available through the occupational health and safety committees that are in hospitals.

M^me^ France Gélinas: Do you, as the ministry, gather those together, if it had an impact on staff or on a patient?

Dr. Bob Bell: There is information in the occupational health and safety committees. It's more the Ministry of Labour that collects information related to potential injury to staff. As you know, we have a joint ministry committee related to workplace violence and improving workplace safety for hospital staff. That's a major goal that the ministry has, and something that's being reflected more and more frequently in quality improvement plans from hospitals.

Currently, a task force that Minister Flynn and Minister Hoskins co-chair will be reporting, I believe, in the fall with some early recommendations. There are some best-practice hospitals recognized across the province. Toronto East General and Southlake hospital, as well as the work being done at the Centre for Addiction and Mental Health, have led the province in terms of establishment of best practices and education of staff, so there is—

M^me^ France Gélinas: But in your work as overseer of the system, do you collect this data that comes from the shared table with the Ministry of Labour when it comes to patients being injured during a violent incident?

Dr. Bob Bell: Certainly, information related to Ontario Ministry of Labour investigations—we would have access to that information from Ministry of Labour colleagues. That information has been accessible, I know, to the workplace violence prevention task force, yes.

M^me^ France Gélinas: So could you share that with us?

Dr. Bob Bell: We can look into that, yes.

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

Le Vice-Président (M. Michael Mantha): Madame Gélinas, il te reste cinq minutes.

M^me^ France Gélinas: Five minutes? Okay.

Can I have an update—I do that every year—on the number of hospital beds in operation by clinical area, and can I have that by LHINs? You do that little chart for me every year.

Hon. Eric Hoskins: I'll look into that for you, as well.

M^me^ France Gélinas: Okay, thank you. The other one is another little chart that I ask for every year—

Hon. Eric Hoskins: Do you ever get it?

M^me^ France Gélinas: Yes, I do.

Hon. Eric Hoskins: Okay, good.

M^me^ France Gélinas: Sometimes I have to pay five bucks through freedom of access to information, but sometimes—

Hon. Eric Hoskins: Let's see if we can make it a little easier for you this year.

M^me^ France Gélinas: Yes, save me five bucks; I'm all for it.

My next question is the same thing. Something I ask for every year is the number of contracts the CCACs have with for-profit versus not-for-profit and the total amount of money that goes to those two. Sometimes I get the hours of care with it; sometimes I don't. If I could get the hours of care in the contracts with it, I would be very grateful.

Hon. Dipika Damerla: Okay, I'll endeavour to work to get you that.

M^me^ France Gélinas: Thank you. The next one is, can I have a breakdown of the provincial portion of funding that goes toward different health units by program area for each health unit? The 36 health units: We know their total budgets and we know how much money you send to each of them as a whole, but I would like it broken down by program area.

Hon. Eric Hoskins: We're just consulting now. We don't have it at hand. I'll look into that for you, as well.

M^me^ France Gélinas: Okay, thank you. The others: I'm not sure we keep this, but I'm just curious. Do we keep the number of hours of agency nurses who work—we'll start with our hospitals. Do hospitals report on that? Do you know? Do you care?

Dr. Bob Bell: The answer is that we definitely have information with respect to full-time nursing hours. That is definitely there. I believe that we have—and I'm going to look for a second here. Do we have agency hours?

Interjection: I'm not sure.

Dr. Bob Bell: We're not sure, Madame Gélinas. We'll find out.

M^me^ France Gélinas: Okay, if you could share that with me. But if you do have the full-time nursing hours per hospital, I would be interested in sharing that. Does this come where we see the difference between RN, nurse practitioner and RPN, or does it come as a whole?

Dr. Bob Bell: In terms of full-time nursing hours, I believe that's RN. But again, I'm not sure, so we'll have to check that.

M^me^ France Gélinas: Okay. If there is more than one category of nurse, could you break it down? If it's just for RN, then it becomes clear by itself.

Dr. Bob Bell: As you know, virtually all nurse practitioners are full-time because they're generally not on shift work.

M^me^ France Gélinas: Yes. But if you have the number of hours, it would be interesting to track this to see where we're going.

Dr. Bob Bell: We definitely have hours worked for those three—no, I can't say that. I've got to check that.

M^me^ France Gélinas: Okay. But if you do have the number of hours worked for those three, I would be very interested in you sharing that with me.

My next one—I'm not sure who it goes to. There have been promises made to caregivers to increase respite in—I think it's called the respite innovation fund. I'm not exactly sure that I have the right terminology. Basically, is there any money in this budget to help family caregivers with respite?

Hon. Eric Hoskins: As you're probably aware, in the 10-point action plan on home care that was announced by government last April, I believe it references specifically, as one of the action points, to increase the provision of respite for caregivers. Nothing has been announced at this point.

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The Vice-Chair (Mr. Michael Mantha): And on that note, thank you, Minister. We will now move on to Mr. Walker, with the official opposition. The floor is yours.

Mr. Bill Walker: Thank you, Mr. Chair. Thank you very much. I hope you'll enjoy my delivery as much as you did my colleague from Kingston and the Islands.

We're getting down in time, so I'm going to ask, if you would indulge me—if you don't have the actual numbers or the specific answer, we'll just note it and you can get it back to me later so that I can get through as much as I can.

Hon. Eric Hoskins: Yes.

Mr. Bill Walker: Can you share with me—if you actually know—what the funding shortfall for long-term care is?

Hon. Dipika Damerla: Can you elaborate on what you mean by that? What do you mean? I'm not sure what you mean.

Mr. Bill Walker: We obviously know there's a boom coming at us. We know there are not enough beds currently, the developed beds, and that you've only accomplished a third of what you said you would.

We know there's a doubling of the wait-list to 24,000 people. Do you even have a number that you know that you should be working on, to make sure we have the services and programs for seniors in long-term-care facilities that we need?

Hon. Dipika Damerla: I believe I answered that question yesterday, but I will try and answer it again.

Mr. Bill Walker: Just the number. I just want to know what number you're working with. What's the total shortfall for funding care right now for long-term care?

Hon. Dipika Damerla: I believe that it's really important to note that from 2008-09 to 2014-15, wait times for long-term-care homes have actually reduced by 6.2%—

Mr. Bill Walker: Associate Minister, with all due respect, I have asked all the time—I don't want to hear what you've done. I just want either a number, or just say, "Decline." That's fine.

Hon. Dipika Damerla: We'll endeavour to get back to you.

Mr. Bill Walker: Thank you very much. We know that the most costly form of care is being in a hospital bed, and that there are a lot of people—7% of people aged 65 and over reside in a long-term-care facility, but there are many more remaining in a hospital bed that should be in a long-term-care bed.

Do you have a number of how many people are in a hospital bed that should be in long-term care, and what the associated cost of that is?

Dr. Bob Bell: According to the access-to-care information that we get from Cancer Care Ontario, looking at the alternate level of care population, Mr. Walker, there are about 2,500 patients across Ontario hospitals who are waiting for long-term care. Some of those have exceedingly difficult problems—behavioural issues—for which there are very few facilities in the province, and that is why they're spending so much time there. Some of those are quite short stays. So 2,500 patients on any given day would include patients who are only waiting for three or four days, or it could include patients who have been there for very prolonged periods of time, waiting for a specific facility that has strong behavioural programming available for people with strong programming needs.

Mr. Bill Walker: Associate Minister, could I just get you to clarify: You said 2,500 beds? Because the number I'm being told by the industry is 24,000 beds—

Hon. Dipika Damerla: What the deputy was referring to was a very specific number, which is the ALC, the alternate level of care. That would be referencing people who are in a hospital who might be better off somewhere else. That's the number he was referencing.

Mr. Bill Walker: Fair enough. Thank you. We'll agree, though, that there are many more than 2,500 people that are going to need long-term-care facility beds, and that's the issue that I keep hearing from the community.

Can you tell me the current average wait time for an individual on a wait-list to transfer from a hospital bed to a long-term-care facility?

Hon. Dipika Damerla: I know we can get you the number, but I just wanted to know if somebody has the number handy. I believe it is actually 68 days.

Mr. Bill Walker: Sixty-eight? Thank you. We know that acuity in long-term-care facilities has been increasing. Despite that, we keep hearing from the community and from the industry that funding has not kept pace, and

there is widespread acceptance that there are too few staff to provide the adequate care that they believe they need, the minimum levels of care. Can you tell me how many PSWs are employed in our long-term-care sector?

Hon. Dipika Damerla: I can't give you an exact number, but I will say this, MPP Walker: Under the long-term-care act, it's very clear that every resident has to have a personalized, tailored plan of care. That plan of care would then dictate the number of hours of care that that person would get from a variety of health care professionals, whether they're PSWs, whether they're nurses. I think the key issue is that care is provided as required. Under the act, long-term-care homes are required to provide the level of care as indicated by their care plan.

Mr. Bill Walker: Thank you. Can you tell me what the copayments were in 2003, and what they are now? If not, if you can't get that, as long as you supply that to me, that would be great.

Hon. Dipika Damerla: Yes, we can try and get that to you later.

Mr. Bill Walker: With that, how many fee hikes has the province brought in over the last 13 years?

Hon. Dipika Damerla: What I can tell you is that Ontario probably has, if not the lowest, I believe the third lowest copay rates for long-term-care homes in Canada, and I believe we have the lowest if you compare just the provinces. If you compare it with the territories, because they get federal funding, we're a little bit higher. While we'll try and get you those numbers, I can assure you that we have by far the lowest copay rates in Canada.

Mr. Bill Walker: Thank you, and a good segue, because I want to ask a question about the Canada Health Transfer allocation. Can you tell me—yes or no—is 100% of the Canada Health Transfer allocated to health care?

Hon. Dipika Damerla: I think maybe the—

Dr. Bob Bell: Just a number that you asked for earlier: You asked for the number of PSWs employed in long-term-care settings, Mr. Walker?

Mr. Bill Walker: Yes.

Dr. Bob Bell: That number is 60,000.

Mr. Bill Walker: It's 60,000?

Dr. Bob Bell: About 60,000. Sixty—six zero thousand.

Mr. Bill Walker: Thank you.

Dr. Bob Bell: And you were asking about Canada Health Transfers? Sorry.

Mr. Bill Walker: Yes. What I just want to know is, can you assure me that 100% of the Canada Health Transfer to health care is actually used in health care, and will you provide audited statements of that nature?

Hon. Eric Hoskins: As you can appreciate, health expenditures take place through a number of different ministries. It's important, when you look at the transfer, that that is understood. For example, there are significant expenditures in children and youth mental health that are expended through the Ministry of Children and Youth Services and not through the Ministry of Health.

We have the financial information as it pertains to my ministry. I don't have at hand, nor is it really in the purview of my ministry to have, a full accounting of expenditures through other ministries that may be directly health-related.

Dr. Bob Bell: Minister, I can speak to the actual sum in the Ministry of Health, if that's appropriate.

Hon. Eric Hoskins: Sure.

Dr. Bob Bell: As you know, Mr. Walker, the Ministry of Health spends about $52 billion. The Canada Health Transfer is around $13 billion, so it's roughly 25%. Certainly, that goes into the general revenue fund, but obviously, we overspend, by far, that contribution from the federal government. So every penny is spent.

One of the questions that has come up previously—I think it was in last year's estimates. There was a question of, was all incremental funding in incremental Canada Health Transfers used in the Ministry of Health? The answer is yes.

Mr. Bill Walker: Okay. Thank you. Can you tell me the total cost of ministry funding for palliative care services? And again, if you don't have the exact number, if you could get that to me, that would be great.

Dr. Bob Bell: We do not have that number. So much of that funding, I can tell you, is absorbed within general internal medicine units and within general hospitals that hiving off a true estimate of what is spent on palliative care would be virtually impossible. We do have a budget for the Ontario Palliative Care Network that Parliamentary Assistant Fraser has sponsored. That amount is available to us and is probably going to come forward just about any moment. Does anybody have the PCN number for this year?

Mr. Bill Walker: While we're waiting on that, I'll just queue the next person up, because I would like to know the total cost for drugs for palliative care patients.

Hon. Eric Hoskins: The cost of drugs?

Mr. Bill Walker: The cost of drugs for palliative care patients, yes.

Hon. Eric Hoskins: I don't believe that the ministry would have that detailed information or collects information with respect to drug expenditures based on palliative state.

Mr. Bill Walker: Where I struggle with some of this, not ever having had the privilege of sitting on your side of the House, is to understand how you set estimates and you set budgets if you don't know some of those things. I'm trying to get my head around: How do you estimate, how do you guesstimate, where you're going to be?

We have a lot of people chasing a lot of statistics. What I hear from almost every industry is that the government continues to ask for more data so that we can be more knowledgeable. Yet when I ask a lot of questions about something as simple, I think, as how much you spend on drugs for palliative care, I don't get an answer.

Hon. Eric Hoskins: We don't have drugs, but we have historical references with regard to government expenditures on drugs. We also know what has recently come into the schedule or is forecast to come online

because of new innovations and developments in our role in the pan-Canadian Pharmaceutical Alliance. We do have very accurate historical information that we can use to base projections on. The fact that we don't actually categorize it according to the condition or the specific environment that the patient has experienced doesn't preclude us from making those forecasts accurately.

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Mr. Bill Walker: Thank you.

Dr. Bob Bell: If I could, just so we can chase down that number, how do you define "palliative care"?

Mr. Bill Walker: Well, I think your total. Anybody who is deemed whatever your criteria is for "palliative"—you're the government; you set the terms and conditions of anybody receiving services and programs of a palliative care nature—we want to track. Whether it's at-home care, whether it's in a hospital, whether it's in long-term care, I just want to know what that total cost is.

Dr. Bob Bell: The reason why we're struggling a little bit with that is that an increasing number of patients are recognized, exactly based on your definition, as having palliative care. The new definition that we're using based on Parliamentary Assistant Fraser's excellent work with palliative care physicians and primary care providers recognizes that probably the best way to define a palliative care patient is to ask their provider, "Do you anticipate that this patient will unfortunately be deceased within the next year?"

Our definition of palliative care, which used to be really focused on patients with terminal cancer, for example, is expanding quite dramatically because of the recognition that patients with advanced congestive heart failure and advanced chronic obstructive pulmonary disease are often recognized by their providers now as being palliative.

The whole underlying framework of who is a palliative care patient is undergoing rapid evolution. Probably the numbers that we have today would be changing in the upcoming years as more people are recognized as having palliative care needs.

Mr. Bill Walker: Sure. Thank you.

We've talked about this a fair bit. Long-term-care homes are short of at least 24,000 beds, from what we received from the industry. That number has continued to increase since January 2014.

We've received a lot of concerns at our office about how the frailest, sickest and neediest elderly patients are not being prioritized for placement in long-term-care beds. Particularly, we've received word of a situation from the Sault Ste. Marie region, where there are some 1,100 people waiting for a long-term-care bed and where particularly male patients are facing a three-to-five-year wait for basic LTC beds.

Alternate level of care or ALC patients who are deemed in crisis are being shuffled into these so-called pop-up nursing homes despite them requiring immediate admission into a long-term-care home. Just a generic kind of—what happened to the rules of choice and consent, and how are these interim or pop-up nursing homes licensed and regulated? Is it under the Long-Term Care Homes Act?

Hon. Dipika Damerla: I'll be very, very clear: I'm not entirely sure what you mean by a "pop-up" nursing home. To be a long-term-care home in Ontario, you need to be licensed by the Ministry of Health and Long-Term Care. If they're not licensed, then they're not nursing homes or long-term-care homes.

I do want to correct one assumption. A wait-list of X doesn't mean X is the number of beds you need; there's throughput as well that you have to consider. I think that's a very simplistic way of looking at it. The better way to look at it—and I talked about it yesterday, but I think it bears repeating—is we are undertaking province-wide capacity planning.

I really, really hope that next year, we will be able to answer some of those very concrete questions that you have around numbers, but again, it's the continuum of care. The question that should be asked is, "What are you investing and what are your plans through the continuum of care," whether that's investing more in home care, whether that's investing more in affordable housing, assisted living or long-term care.

It's that whole continuum that we are looking at that will inform some of the questions that you're asking. But I think it would be too simplistic to take a wait-list at a point in time, which changes all the time as well, and come up with a number.

Mr. Bill Walker: Thank you very much, Associate Minister. I'll be pleased to continue to shine the light on you next year to get those answers.

I take your basic concept, but we're hearing from the industry 24,000. If you want to take 4,000 off or add 4,000, I get that. But 20,000 is not an insignificant number, and we know the demographic is coming at us. The reality is whatever form—all we want to see is a plan and that you're addressing it. Again, I'm going to go back to the beds that you said you would redevelop. You're happy that you have developed a third of them. I, as an Ontario taxpayer, am not happy, if we know that there's X, whatever that X number is, that you've only accomplished a third. All I want to say is we want to make sure of that.

Yesterday, you suggested that you were "comfortable in being prescriptive" with "the four funding envelopes." We've heard a lot of feedback from the operators, from patients and from their families that they don't share that. They want to have an ability to be more flexible. They want to be able to do things like have new mattresses to reduce the incidence and prevalence of pressure ulcers, or to install and update fire sprinklers. They know that there are things. Those operators know exactly what their homes need and how they can provide better levels of care. We're really hopeful that you'll do that.

Where I'm going with this one is there are some reconciliation funds that you take back from facilities, if they're not used for those prescriptive needs. Can you tell me—and again, if you don't have it, I'll take it later—

how much money you take back on an annual basis, or in the last five years, if you will, in reconciliation funds? I'd also like to know, when those are taken back, what's done with that funding. Where does that pool of money sit and what do you utilize that money for, if it's not within the long-term-care facilities?

The Vice-Chair (Mr. Michael Mantha): Mr. Walker, you have five minutes left.

Mr. Bill Walker: Thank you very much, Mr. Chair.

Hon. Dipika Damerla: Deputy, is there somebody who wants to give—I'll start by giving an overview, but I wanted to know if you have the numbers, or will we be looking into them?

Dr. Bob Bell: We do not have the numbers here.

Hon. Dipika Damerla: We do not have them. I just wanted to say that the one thing I do know is that we fund based on utilization. If a home has an empty bed, then that doesn't get funded. There's a funding formula but it's not that we are taking funds away that they would have needed to use; it's if you had an empty bed or if your occupancy isn't there. We fund based on each resident. The funding follows the resident. It's really important to unpack that homes get the money they need for the residents that they have, but we'll endeavour to get back to you in terms of any details that you asked for.

Mr. Bill Walker: Thank you. Because we're running out of time, I'm going to switch gears totally.

Yesterday, the Ontario Association of Cardiologists wrote an open letter to the Auditor General, asking her to examine two issues: (1) They believe that certain cardiac rhythm monitoring tests were and are being inappropriately over-billed to OHIP. Cardiologists urged the ministry in July 2015 to put a stop to it but it continues. (2) In October, the government unilaterally waived the requirement for a physician to be present during the performance of cardiac ultrasound services, boosting profits in the commercial lab sector.

So the association of cardiologists is alleging that certain ambulatory cardiac rhythm monitoring tests were and are being over-billed. Could you explain in more detail what they are concerned about and what you've done to address that issue?

Hon. Eric Hoskins: Obviously, I'm aware of the concerns. We listened to them some time ago and the ministry has acted on them. I'm just looking at the letter itself.

First of all, it's important to emphasize that the decisions that we've taken in reference to the concerns that they have raised have had no impact on quality of care nor have they infringed upon best practices or clinical guidelines in existence. For example, I know one of their concerns was with regard to their presence when certain diagnostic imaging tests are conducted. We took an important step. There was a transition period and we now require all facilities that undertake echocardiograms to be accredited facilities, and that is now the case for them to be reimbursed through the OHIP system.

The first of the two items that was identified as a concern by this particular group of cardiologists was in reference to technology that had developed and there was some concern about how the billing was being undertaken by the company on behalf of the cardiologists. There were some schedule-of-benefits concerns that were raised which we have addressed and clarified to the company and the cardiologists involved. We have clarified with them the concern that we have and the appropriate method of billing for that diagnostic test or tests that they were providing.

Mr. Bill Walker: So you're monitoring and we can check that next year to see if there has been any dramatic increase in those types of billings. Thank you, Minister.

The other one—and we're running out of time here. I'm pleased to see some more money put into the palliative care sector. You've agreed to 20 new hospices across Ontario. Can you provide me—again, if you don't have it today—a list of where those facilities will be allotted and how many beds per facility?

Hon. Eric Hoskins: This is part of the important work that the member for Ottawa South, John Fraser—I think it's Ottawa South—

Interjection.

Hon. Eric Hoskins: Thank you.

Interjection: You're never going to be Speaker.

Hon. Eric Hoskins: Yes, everybody was quiet. Thanks for the help.

Interjection: But you were right.

Mr. Bill Walker: Good guess.

Hon. Eric Hoskins: —the work that he's been doing. There has not yet been any announcement on the specific allocations. You're right about the commitment to funding 20 additional hospices. That being said, I believe that we're close to being able to make that determination.

Mr. Bill Walker: Great, and I ask that partly because, again, I go back to the long-term-care beds. We didn't have a plan, we haven't seen one, and we don't get the list, so we want to make sure. Obviously, there were two LHINs that didn't have any provision for those services, so obviously we're hoping they're—

Hon. Eric Hoskins: You certainly won't have to wait until next year's estimates to get the answer.

Mr. Bill Walker: Excellent. Thank you very much, Minister. It has been a pleasure.

The Vice-Chair (Mr. Michael Mantha): On that note, thank you, Minister. Thank you, Mr. Walker.

It being so close to the hour—le Comité permanent des budgets des dépenses, cette séance est maintenant levée.

The committee adjourned at 1800.

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