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2nd Session
41st Parliament

Wednesday 1 November 2017

Chair: Cheri DiNovo
Clerk: Eric Rennie

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Mercredi 1er novembre 2017

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STANDING COMMITTEE ON ESTIMATES

Wednesday 1 November 2017

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DES BUDGETS DES DÉPENSES

Mercredi 1er novembre 2017

The committee met at 1607 in room 151.

MINISTRY OF HEALTH AND LONG-TERM CARE

The Chair (Ms. Cheri DiNovo): Good afternoon, everyone. We are going to resume consideration of vote 1401 of the estimates of the Ministry of Health and Long-Term Care. There is a total of eight hours and four minutes remaining.

Before we resume consideration of the estimates, if there are any inquiries from the previous meeting that the minister has responses to, perhaps the information can be distributed by the Clerk. Are there any items, Minister?

Hon. Eric Hoskins: Not currently.

The Chair (Ms. Cheri DiNovo): Okay. When the committee last adjourned, the government had eight minutes remaining in their rotation. Ms. Hoggarth.

Ms. Ann Hoggarth: Thank you, Chair. I think there's one thing that we can all agree on, no matter which side of the House we're on: All Ontarians deserve access to high-quality health care. Patients come first, and every decision we make is centred around helping people in their everyday lives by providing high-quality, convenient care.

Since 2003, one of the top priorities of your ministry has been reducing the amount of time Ontarians wait for surgical priority procedures, as well as in emergency departments. I'd just like to interject this personal thank you; my daughter was rushed to the hospital on Monday morning and she had an operation 14 hours later. The good news is it was just her gall bladder. In 1972, I had an operation for my gall bladder and it took three months to get in to have that done. She also got a bed very quickly that very first night.

Can you please provide the committee with an update on the progress made on tackling wait times and advise on any future initiatives that are planned?

Hon. Eric Hoskins: I'd be happy to. First of all, I apologize; I'm sounding a little bit hoarse. I can't guarantee that I'm going to survive until 6 o'clock, but if I lose my voice, I know I've got a PA who's willing and able to step up in my place.

Of course, wait times are an important measurement of how our health care system is functioning, so it's something, as you can appreciate, the government, my ministry and I take very seriously.

I had the opportunity, in fact, in question period this morning, if you recall, to give some indication of how we compare to our peers not just across Canada but indeed around the world. It's clear that—not to say we're not without our challenges, which explains why we continue to invest, including in the spring budget, in additional measures to further shorten wait times—we perform exceptionally well compared to our peers across the country and around the world.

I had the opportunity to mention this morning that, when we took office in 2003—in fact, under the previous government of the Progressive Conservatives, wait times weren't even measured. We were the first government to begin to measure wait times. When we began measuring them in 2003, we found that we were the worst or among the worst in the country for important procedures. But I can say with confidence and, I think, with some pride that we've gone from worst to first, or near first, across a whole array of categories, including from worst, under the Progressive Conservatives, to first for reducing wait times for hip and knee replacements, for cataract surgery, for cardiac care, for radiation oncology, for MRIs and CTs and ultrasounds. Those are, obviously, measurements that we ourselves take, but also we have independent third parties that look at our data and declare on behalf of themselves our performance. The Wait Time Alliance, for example, has consistently rated us as among the best if not the best, including those specific measures.

I gave the example again this morning of cataract surgery where—not to say that we don't need to continue to make investments to continue to reduce those times. Reducing the wait time for cataract surgery and adding new cataract procedures was part of this fiscal year's budget as well: dedicated funding that would go towards that this fiscal year and in the out years as well. But when you look at the wait time for cataract surgery, it's actually half of the average of the OECD, which kind of represents the majority of the mid- to large-sized industrialized countries in the Western world. Our wait time for cataract surgery is significantly lower, for example, than in the UK or Denmark or Australia. I've given the example for hip replacements as well: Our wait time is not only lower than the OECD but lower than Canada as a whole and lower than the United Kingdom. The wait times for knee replacements are half of the OECD average.

Clearly, it's not the only measure that's important. Quite frankly, what probably—I think we could agree—

is most important are outcomes: how it impacts people's health and aids them in recovering from their ailment or keeping them healthy. But our performance on those measures is exceptionally high as well.

It's interesting that, across most indicators, in the United States they spend twice what we do on health care on average, but almost across the board, our outcomes are better despite them spending considerably more per capita than we do in Canada. So I think we can be proud both nationally and in this province.

But it does speak to the work, going forward, that needs to happen. When you think about hip and knee—I'm fortunate; I've got an orthopedic surgeon to my right. But as we have a growing and, particularly, an aging population, and a population that's aging in many respects in a more healthy fashion, there is not only the requirement, but the opportunity and, I think, the expectation that we make these sorts of procedures available. For hip and knee, it's a good example where we need to be cognizant of how our demographics are changing. The needs of Ontarians, particularly our seniors, are changing and their lifestyles often reflect lifestyles where those sorts of measures are even more important. It's obviously our objective to keep people as healthy as long as possible.

The Chair (Ms. Cheri DiNovo): Minister, you have just about a minute.

Hon. Eric Hoskins: I'm afraid I'm not even going to be able to invite the highly talented ministry officials to come up and speak in more detail about this, but maybe to get back to our 2017 budget: It reflected roughly a $1-billion investment in health care. We're adding $7 billion more over the next three years. We were, in this year's budget, investing $1.3 billion over three years specifically to reduce wait times—just under $300 million of that for this fiscal year alone. That wait times funding includes particularly, as you can imagine, hospitals, but not just the hospital environment. It allows us to do things like add 2,100 more cataract surgeries, add 2,800 more hip and knee replacements, 28,000 more MRI hours—

The Chair (Ms. Cheri DiNovo): I'm afraid you will have to hold it there, Minister.

We now move to the official opposition: Mr. Yurek.

Mr. Jeff Yurek: Good afternoon. Just a quick question, tapping back to the non-profit corporation that you're creating for your PSWs. I guess I didn't use the right word in one question. This corporation already has an interim CEO working right now?

Dr. Bob Bell: My understanding is, we haven't confirmed that. I don't think the contract has been negotiated. We've identified somebody, but I don't think we've actually completed a contract with the individual as of yet.

Mr. Jeff Yurek: Okay. So you wouldn't be able to inform the committee on what you expect their wage to be? Do you have a range?

Dr. Bob Bell: I'm not aware of that at this point. Do you know, Patrick, what it might be?

Mr. Patrick Dicerni: Yes. With the manner in which this agency has been established, we've brought on an interim agency lead—

The Chair (Ms. Cheri DiNovo): Could you introduce yourself?

Mr. Patrick Dicerni: My name is Patrick Dicerni. I'm the assistant deputy minister in the strategic policy and planning division of the Ministry of Health.

With respect to the manner in which we—

Interjection.

Mr. Patrick Dicerni: We've brought an agency lead in, and we're in the midst of working out the final details related to what his employment would look like. However, the individual is not technically employed by the agency at this point.

Mr. Jeff Yurek: Do you have a wage range that you—

Mr. Patrick Dicerni: Not at this point.

Mr. Jeff Yurek: You don't have an idea where—

Mr. Patrick Dicerni: I wouldn't want to speculate.

Mr. Jeff Yurek: So you don't have any idea of how you're going to pay any of the staff members, you have no idea what this is going to end up costing the system and you don't know how the back office function is going to operate?

Mr. Patrick Dicerni: Let me provide a little bit more precision on some of those statements. With respect to our discussion on this topic yesterday, we clarified that there was a $2.9-million interim operating budget for this agency, so with respect to some of your questions related to how the back office services would be funded, that is the manner in which they would be funded. To answer your question of yesterday with a little bit more precision, in terms of how we are contracting or accessing those back office services, that's what's being worked through right now in an effort to make sure that we're optimizing and leveraging assets in the system. We're looking for partners in this respect. With respect to how the employees would be compensated, there would be some program design that is still being worked out, and that would be, of course, largely influenced by the establishment of the executive within this agency and the board within that agency. But the service dollars would be all identified within our current home and community care spend.

Mr. Jeff Yurek: So those service dollars are going to be pulled from the existing LHINs to this agency?

Dr. Bob Bell: They will be expended within the LHIN, from the home care budget allocation made to the LHIN. We would be using care dollars from that LHIN to pay for the service provided through this agency.

Mr. Jeff Yurek: With the creation of this agency and the spend to develop it and run it, you're basically still going to be servicing the same number of people that you were servicing prior to this agency starting.

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Mr. Patrick Dicerni: The availability or client group for this agency is defined by the client population that we've defined for this group, which, as we mentioned

yesterday, is the chronic long-stay home care client assessed at about 14 hours a week of home care personal support services being required. Service would be a function of the number of people accessing home care and being assessed for that level of care.

Dr. Bob Bell: As you know, we've been increasing—sorry, this is Bob Bell, deputy minister—our home care spend by about 5% per year. So we would expect that this would fit within that incremental funding envelope.

Mr. Jeff Yurek: Okay, that's enough on that topic. That's enough for this week on that one.

In the 2017 budget, in a section about ALC utilization, it says that "$24 million in funding will be invested in new, innovative models to ensure patients are receiving care in the most appropriate care settings possible—at home or in the community." Can you let us know what these innovative models are?

Dr. Bob Bell: These are probably best demonstrated by what happens with patients who are designated as alternate level of care today, Mr. Yurek. As you know, a home care coordinator assesses a patient's needs. A physician or physician-delegate assigns them as being alternate level of care and no longer needing acute-care services. Their needs are then assessed, and it's possible they might be defined as requiring long-term care.

These patients may have been living well at home previously. They've been admitted to hospital for, say, 10 days or two weeks for management of pneumonia. They may have developed mental status changes during that time—delirium etc. As you know, in hospitals, seniors and frail people tend to get deconditioned quite rapidly. Our home care coordinators might make a decision that somebody now needs to go into long-term care, at a time when patients are literally at their worst.

What we're hopeful of is, by putting them in a more ambulatory setting for a period of time, focusing on re-activation, focusing on rehabilitation, a certain proportion of these patients will indeed be able to go home. We're focusing on patients who have a place in the community to return to, people who may be able to return home rather than go to long-term care if they have a period of reactivation treatment.

We've got models that have worked in this fashion in Ontario before: in Hamilton and in programs at Lakeridge in the Oshawa area, where up to 25% or 30% of people have been able to go home after being designated as long-term care. This is the kind of transitional setting that we're looking to provide with a lot of strong connections back to the hospital that the patient was in when they were designated as being ALC requiring long-term care.

Mr. Jeff Yurek: Can you comment—and this is an occurrence in my riding; I'm sure it's across the province. I probably receive calls monthly on this, where a family member is ALC in the hospital, the families are unable to support the patient at home and it's a three-year wait for a long-term-care home out of that bed. The patient is told, "If you go home, you will be deemed 'crisis' and bumped up the list."

Help me understand why we need to put the patient's safety in jeopardy by shipping them home in order to bump them on to crisis, when they know they are in crisis. I have too many people whose families are facing that. I don't know if you think that's fair or not.

Dr. Bob Bell: Patients who are designated as being crisis in community and patients who are designated as ALC for long-term care—as I understand it, Brian—have equal status on the long-term-care waiting list. Is that right?

Interjection: Crisis, priority 1.

Dr. Bob Bell: Yes, crisis and priority 1. In the hospital, they are in the same kind of status. It would be unusual that someone would be told to go home to achieve a higher status on the long-term-care waiting list.

Mr. Jeff Yurek: You may want to call the South West LHIN and have a conversation with them, because that's happening. It's happening to my constituents in Elgin county. Maybe you would want to review that, because I'm dumbfounded when I'm told that they have to be put in an unsafe condition in order to be bumped up to get the care they need. It just doesn't make sense.

Dr. Bob Bell: We'll definitely follow through on that.

Mr. Jeff Yurek: Okay.

Hon. Eric Hoskins: I've got, I think, a good example of what you had asked a question about with regard to ALC options and the funding that was expressed in the spring budget, and I can do it very briefly. There's a program in Hamilton that's administered by the city of Hamilton. It's called First Place. There will be individuals who are ALC in hospital who don't require long-term care, but there's an issue of affordability. It's not dissimilar to the example, in some respects, that you gave.

What this First Place allows—in fact, it's an apartment building, or part of an apartment building, in downtown Hamilton that will allow, through this funding, 40 seniors to be able to leave ALC and to be provided with affordable housing in that environment and at the same time receive a whole range of programs that are offered at First Place: recreational activities, wellness, access to a food services program, a café, congregate dining, arts and entertainment programs and the like. It's going to sort of answer that question, which is not an uncommon one, where the family or the individual isn't able to afford the options outside of a hospital environment and they don't necessarily require a long-term-care stay, or perhaps that becomes the only option because of affordability reasons. This, in the case of the Hamilton example, is going to provide that option.

Those are the sorts of things that many of our communities—in fact, for the funding announced in the budget, we reached out to our LHINs, who then in turn reached out to their partners and came back with proposals, many of them to some extent already in existence and others that were clearly worth investing in. This will help have that impact of pulling people out of hospital.

Then lastly, which is the one we're all perhaps most familiar with, is the former Humber River site at Finch.

A portion of the funding, at least, for that is coming out of the $24 million that was announced in the budget. These are individuals, many of whom will be ALC, who will be able to get transitional and more appropriate rehabilitative care in that environment.

Dr. Bob Bell: The other budget allocation within that $24 million is about $3 million for providing over 200 supportive housing positions for patients who are within that position of being ALC in a hospital waiting for long-term care. Of course, these are frail seniors who will benefit from physiotherapy rehab services provided through home care within the supportive housing environment.

Mr. Jeff Yurek: On August 10, it was announced that surgery and specialist wait times would be reported by Health Quality Ontario rather than the ministry. Has the data collection method changed for wait times?

Dr. Bob Bell: The addition to our surgical wait times recently has been the addition of wait 1s; that is, time to see a surgical specialist. For the times for wait 2, which is time from decision to treat to surgery, the methods for collecting data have not changed. We've gone through a process of discussion with patients, focus groups. Health Quality Ontario has done that, looking to see what the most usable way of reporting that information is. We're reporting it in a number of ways now on the ontario.ca/health website.

Mr. Jeff Yurek: I've heard from some health care practitioners concerns about the accuracy of the data reported by HQO. Wait times reported by HQO are lower than those that were reported by the ministry. Have the data benchmarks changed?

Dr. Bob Bell: The data collection, as you know, was signed off on by three impartial folks, including the president of the Ontario Hospital Association. Maybe I could ask Melissa Farrell to refresh my memory as to whether we've changed the way we describe wait times currently.

Melissa Farrell, ADM for health quality and funding.

Ms. Melissa Farrell: The change that occurred this summer in the way in which the information is being reported is that we moved from reporting the 90th percentile to a change to the median wait time. That's actually based on the fact that in the consultations with patients and the public, the majority of patients and the public actually saw that information as the average or as the median, and it made more sense to be conveying that information in the way that they were interpreting it. So the information was changed. It has all been available; it's just a different way of reporting it.

Dr. Bob Bell: I believe we also report the proportion of patients who are seen within target time as well.

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Ms. Melissa Farrell: Correct.

Mr. Jeff Yurek: Yes, it's just a quandary. Looking at a chart I have here, using the ministry's reporting and the new HQO reporting, it looks like wait times on the same set of data in the same month went from 395 to 269. It's just interesting that all of the wait time data seem so much better now that you've changed the way you're reporting it. But people aren't really getting—

Ms. Melissa Farrell: We could look at it.

Hon. Eric Hoskins: We could have a look at that specific example, if you want, and then we could provide an explanation.

Mr. Jeff Yurek: Okay. Thank you.

A Kingston doctor recently shared a letter she received from the neurology division at Kingston General Hospital regarding a referral of one of her patients indicating that the wait-list would be 4.5 years to see a neurologist. The letter suggested she try Toronto or Ottawa. Do you find this acceptable?

Hon. Eric Hoskins: I'm sorry, I missed the beginning of that. I apologize.

Mr. Jeff Yurek: It's okay. It's a letter, basically, from a doctor, which she received from the neurology division at Kingston general for a referral for one of her patients, indicating the wait-list is 4.5 years to see the neurologist. She was told to go try Toronto or Ottawa. Do you think that's acceptable?

Hon. Eric Hoskins: I'm aware of that letter. There is partial information available on it—probably, appropriately, for privacy reasons. I think an individual tweeted it, and not necessarily the individual who was the subject of the referral. We are endeavouring to understand if there's a role that we can play in helping to better understand that challenge, if it exists as it's portrayed, and help to resolve it.

Mr. Jeff Yurek: What would you find an acceptable wait time to see a neurologist?

Hon. Eric Hoskins: Well, I think it depends on many characteristics and the nature of the complaint. If it's an individual, for example, who has had long-standing—the length of a decade or more—occasional or chronic headaches that they're concerned about or a gradually worsening chronic illness that's long-standing, then obviously the wait time that you would expect would not be the same as for someone with a more urgent or acute presentation of something that clinically might be assessed as being highly problematic or even dangerous. So it's difficult to express that.

I think that physicians, through their work—particularly those of us who work in the primary care system—in a sense do that triage as the referral takes place, understanding that often that requires a certain degree of interaction with the specialist who's being approached for the referral itself.

Certainly, again, I think it's challenging, and I would hope you would agree, a little bit problematic to be able to ascertain the nature of this particular example given that the information that has been provided publicly is both partial and doesn't reflect at all the other circumstances that might be involved. But we're certainly endeavouring to see how we might be able to help.

Dr. Bob Bell: Would you mind if I filled in there, Minister? Just a quick comment: We don't have wait times on medical specialty consultations, only on surgical

consultations. Medical wait times are not gathered anywhere in Canada.

We have made an investment this year in the System Coordinated Access program, which is an e-referral program currently being implemented in Waterloo Wellington. This will give primary care providers a method, right from their electronic medical record, of sending consultation requests to physicians. This will be the first time in Canada that we're able to start gathering wait times for non-surgical consultations.

This is a way that we can start addressing this problem, because, as you know, quite often the problem is not available specialty; it's wait-time management. If you're waiting to see the person with the longest wait time, that's a problem, as opposed to going to someone whose wait time is shorter and more accessible.

The Chair (Ms. Cheri DiNovo): Mr. Yurek, you have a minute and a bit.

Mr. Jeff Yurek: A minute and a bit. With that answer, there's $245 million in the budget for wait times. How is that going to be used? Is all of that money going to that program, or how is that money being used in the system to lower wait times to specialists?

Dr. Bob Bell: There are a variety of investments being made. The assisted coordinated access is being managed within that line. That's an IT investment. The other elements are being used for increasing quality-based procedures. The number of hips and knees, as the minister said, has gone up by 8% this year, 2017-18. The number of cataract surgeries has increased, and the number of cardiac procedures. Investing in undertaking more procedures is part of what the wait times is all about.

We've also noticed in managing wait times the importance of having queue management. In Champlain, the wait time for hips and knees has gone down by 50%, not through any investment in surgeons or in OR time, but just by ensuring, through central intake and triaging, that people are being referred to the shortest wait time as opposed to the longest. These are all things we're responding to.

The Chair (Ms. Cheri DiNovo): I'm afraid the time is up. Now we move to the third party. Ms. French.

Ms. Jennifer K. French: I'm glad to be able to ask a couple of questions on behalf of my community, which I'm sure would like to how much worse the overcrowding situation has to get before the government will do something. I do have more focused questions than that for you, but I would like to talk about hospital overcrowding, because that is a reality that is hurting members of my community in Oshawa, Whitby and Durham.

We asked Lakeridge Health directly for information about some of the pressures they're facing. Some of the specifics that I'll share with you: In January 2017, Lakeridge Health Oshawa's mental health beds were operating at 114.67% occupancy; in February, it went up to 117.39%; in March, it was 115.44% occupancy; in April, 116.77%; and in May, it hit an astonishing 123.04% occupancy. That would mean, on average, Oshawa's mental health beds were operating at 117.49% capacity from January through May of this year.

At Lakeridge Health Ajax-Pickering, the acute occupancy rates were 102% in January. Perhaps you saw the Globe and Mail article from May, which was, "Hospital Overcrowding Has Become the Norm in Ontario, Figures Show....

"The Ajax and Pickering site of Lakeridge Health ... had the highest average occupancy rate" of all hospitals in Ontario "in its acute-care section at 107.4% over five years leading up to the end of 2016."

So I will ask, why is it acceptable to you and to this government to force hospitals in Oshawa and Ajax-Pickering to continually operate with occupancy rates over 100%?

Hon. Eric Hoskins: Thank you for that question. It's important in the context of Lakeridge and Durham to speak and think of short-term as well as medium- and long-term capacities. As you're aware, as with Scarborough region, with Durham region, they received last year a planning grant to be able to determine what their out-years requirements would be for acute hospital care and to plan accordingly. We're working closely with Lakeridge, of course, and the various hospitals that comprise that corporation, as they look towards the future—many parts of Durham are rapidly growing and changing, as you can appreciate—to accommodate those changing needs.

When it comes to the immediate, I have the capacity figures for the Oshawa site, for example, of Lakeridge Health from April through to September. I can say with confidence that during those six months, the Oshawa site was never over capacity. But notwithstanding that information, the announcement that I made a week ago Monday, just 10 days ago, of the 1,200 acute care in-patient beds across the province—the equivalent of six new community hospitals—there is an allocation within that, of course, to the Central East LHIN. Part of that allocation—22 acute in-patient beds—is specific to the Oshawa site of Lakeridge Health. So they have received an allocation of 22. I think it's important to re-emphasize, as well, that we wanted these to be conventional beds that were ready in a matter of days or a few shorts weeks for them to be activated. That will be the case at Lakeridge.

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In addition, because I know you referenced mental health and that's of course a very high priority of this government, with that announcement last week, part of that—perhaps it didn't get as much attention as it might have—are 20 further care spaces at Ontario Shores for mental health. That is a partnership between Ontario Shores and Lakeridge Health to provide that service and to help to decant, if you will, from the hospital site in Oshawa itself.

In addition to that, we committed to and are providing, at the Ajax-Pickering site, 22 new mental health beds that will be up and running in the next number of months. So, all in, that represents 64 beds allocated to Lakeridge. But, I'll say, in addition to that as well the LHIN has an as yet unallocated number of beds that were announced last week of an additional 28 beds. Of course, some or all of

those potentially could be allocated to Lakeridge as well, based on need.

Ms. Jennifer K. French: Thank you for that. But to your point when you were referring to when it was or wasn't over capacity, —Tom McHugh is the executive vice-president of patient services at Lakeridge. When he was approached on this issue recently, he did say that what has been unprecedented over the past year is that the spike in patient volumes that they normally see during the holidays or the flu season—that that spike wasn't a spike but it was unprecedented in that it never went away. So, as he said, in the middle of July when they would otherwise be stable with their volumes, they were seeing flu season numbers. So it seems to be that this is the new norm, that it isn't just seasonal. So I think that that is an additional challenge.

But regarding your announcement—as you said, 10 days ago on October 23—of the additional 22 beds in Oshawa, how many additional mental health beds will be added to specifically grapple with Lakeridge Health Oshawa, with occupancy rates that are hitting as high as 123? I heard your numbers about Ontario Shores, and that's fine, but the Lakeridge Health Oshawa specifically, how many additional mental health beds will be added?

Hon. Eric Hoskins: As I mentioned, the 20 beds that have been allocated for Ontario Shores have been allocated on the basis of a request and a partnership between Ontario Shores and the Oshawa site of Lakeridge. And then I mentioned as well the additional 22, I think it was, which are part of the same corporation, Lakeridge Corp., with the Ajax-Pickering site.

Ms. Jennifer K. French: About those beds, though, the 22 for Ajax-Pickering are allocated specifically for mental health.

Hon. Eric Hoskins: Yes.

Ms. Jennifer K. French: Those are mental health beds. So your announcement didn't include mention of additional beds for Ajax-Pickering that would be, I guess, acute care beds or conventional beds—non-mental-health beds. Can you tell us, will there be any additional beds allocated to the Ajax-Pickering site?

Hon. Eric Hoskins: There may be. I had referred to the 28 as yet unallocated beds, which will be allocated based on need. In the first instance, as we worked very closely with the Ontario Hospital Association, who did an inventory of all hospitals across the province, we specifically asked for opportunities—at least in the immediate—in the first instance of that first allocation of beds that could be activated within two to four weeks. That's why we purposely held back an allocation for each of our LHINs, because there are instances when beds can be made available and activated but it may be outside that immediate time frame.

Ms. Jennifer K. French: Just so I'm clear, when can we expect those—that will be after we're finished estimates—so everyone can be told maybe?

Hon. Eric Hoskins: Again, we're working closely with the OHA and the individual hospitals and our LHINs to determine what those allocations should look like. I know there have been allocations that have taken place since the announcement, but because the nature of the beds might be slightly different, it was important for us to make sure that all of these beds were opened this calendar year. We felt it was important to begin with those that were bed-ready, if I can describe it that way. Now we're moving into the process with the hospitals themselves.

So I can't give you a specific time frame, but our overall objective was for the roughly 1,200 acute care inpatient beds to be activated this calendar year.

Ms. Jennifer K. French: Okay. The deputy minister has told this committee that the ministry collects occupancy data on a daily basis at midnight, and data on how many patients are admitted in the emergency department, which is also collected daily. Will the minister table this information with this committee for Oshawa and Ajax–Pickering, and will you do it before estimates hearings are completed so we can discuss it with you?

Hon. Eric Hoskins: Since the deputy referenced that, I'm happy to speak to him about it.

The Chair (Ms. Cheri DiNovo): Madame Gélinas?

M^me^ France Gélinas: Change of topic: We're going to talk about dental care. The total amount of money that was assigned to Healthy Smiles versus the total amount that was spent is quite far apart. For this year, do we have any indication whether the full $150 million that was allocated to Healthy Smiles is actually going to be used?

Dr. Bob Bell: Yes, we do.

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

Dr. Bob Bell: I'll ask my colleague Roselle Martino, ADM of health promotion and public health, to tell us about the increased uptake in the Healthy Smiles program.

Ms. Roselle Martino: Roselle Martino, assistant deputy minister, population and public health division.

The uptake for the program has been significant since the integrated program was launched last year. We will be using our full allocation, and we're actually running a bit over as well.

I'll get the information and submit it to you, in terms of the—were you looking for the breakdown of which health units, or just the allocation?

M^me^ France Gélinas: Both.

Ms. Roselle Martino: The spend against the allocation.

M^me^ France Gélinas: I'm also interested in looking—if I look in my area, it is the Sudbury and District Health Unit. The data that is available is for the health unit as a whole, but the health unit covers a huge geographical area. So is there any way we could see, on a geographical basis, the participation rate as well as the number of dentists who participate in different areas? To say that there are seven dentists in the Sudbury and District Health Unit who participate in Healthy Smiles is of little comfort if you live in Chapleau, which is a four-hour drive to Sudbury.

Hon. Eric Hoskins: I'd be happy to look into that for you. I agree that that's important information.

Mme France Gélinas: Thank you. Along the same lines, can we see who is accepting new patients, as in who bills for the new patient exam procedures code? I am having a really tough time finding dentists who will accept Healthy Smiles patients.

1650

Hon. Eric Hoskins: Okay. So adding that to the other data sets that you had just referenced, I'll see what I can do. I'll talk to the ministry about that, of course.

Mme France Gélinas: Within the spending rules, if such rules exist, are there rules that say because people in northern Ontario have a hard time finding a provider—does that mean all of the money could be spent in the Toronto health unit area because we in the north cannot gain access because nobody participated in the program, and the $150 million will be gone?

Hon. Eric Hoskins: There's an allocation, as Ms. Martino has said, that we try to live within, but it's an open-ended program in the sense of who is eligible for it. It wouldn't be the case that funds—there isn't a designation of funds by region. There is an allocation based on both the population that can be served in terms of eligibility as well as past practice. So it wouldn't be the case that it would get absorbed by another—in a sense, it's an open-ended program based on eligibility. I think we're at about 70% of the eligible kids who are availing themselves of this.

Dr. Bob Bell: Correct.

Mme France Gélinas: He's looking at you?

Ms. Roselle Martino: Yes. Yes, they are.

Hon. Eric Hoskins: Yes. That would not be the case, the concern that you rightly expressed.

Mme France Gélinas: I am really glad to hear that 70% of the eligible children are taking advantage. Could we have this broken down into geographical areas, either by health units or even sub-LHIN regions? I have a feeling you will see great differences coming from northern and rural Ontario.

Hon. Eric Hoskins: Yes, and that's important information, of course. It helps guide us in terms of where we need to invest more, partly in promotion of the program itself. I'll add that to the other data sets that you've asked for, and I'll talk to the ministry.

Mme France Gélinas: Thank you. What happens once the allocated $150 million is used up? Do we stop? What happens?

Hon. Eric Hoskins: If eligible children receive service, they will receive that service. Again, it's an estimation, it's an allocation—

Interjection.

Hon. Eric Hoskins: It's uncapped. Yes, that's the best word. It's uncapped. We allocate based on our best estimation of what we think that annual expenditure will be, but it is an open-ended, uncapped program, so if you're eligible, you can continue to receive that service even if we surpass that allocation.

Mme France Gélinas: I tried to look at this as best I could, but was any new money allocated so that the dental suites that exist either in public health units or in community health centres that are not fully used—lots of them are not. Was there new money available for them to be able to use those suites?

Interjection.

Ms. Roselle Martino: Yes. It's not that there was new money available. They were absolutely able to use the suites for not just Healthy Smiles services. If they were looking to treat adults, for instance, when using the actual suite services, they were able to use that infrastructure to treat not just Healthy Smiles but other dental clientele as well who needed the service.

Mme France Gélinas: Okay. There was no new money this year to help with adults who do not have coverage under ODSP or OW to gain access to dental services?

Ms. Roselle Martino: The Healthy Smiles program is for children and youth up to 17 years of age.

Mme France Gélinas: I guess you all know that there are adults and seniors who also have a lot of trouble accessing dental.

Hon. Eric Hoskins: Yes.

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

Mme France Gélinas: I don't know how you keep your stats on dental. I have tried to go and gain much of this myself so I don't waste your time, but I would be curious to see if there are any detailed data sets under the Emergency and Essential Services Stream versus prevention versus—

Hon. Eric Hoskins: Apparently there is, yes.

Ms. Roselle Martino: As the minister said, we'll look into getting you the actual data. What I can tell you is what we collect. It's important to know that we do collect the number of dentists who participate in the program. We do collect the fee-for-service because there are fee-for-service dentists, and we also collect information from the health units in terms of the salaried public health dentist, right? So there are different streams of how we collect the claims. We also have a way of breaking down which streams of the service are taken up. That is what we collect, and as the minister said, we will look at getting you that information.

Dr. Bob Bell: There is information under the National Ambulatory Care Reporting System—NACRS—which is from emergency departments, around people who are seen for dental diagnoses. It's not exceptionally accurate but there are classifications for those conditions that appear in NACRS.

Ms. Roselle Martino: It's a different stream.

Dr. Bob Bell: Yes.

Ms. Roselle Martino: You're talking about the Healthy Smiles emergency stream.

Mme France Gélinas: Yes. Through Healthy Smiles, is there a day where this information will be available publicly or will be easier for people to access? Or is it really something like we have to request it from you? Is there an intention to make that information more readily available? I'm really focusing on who in the north has access versus the rest of the province.

Ms. Roselle Martino: What I would say is that for the Healthy Smiles program, one of the main delivery agents is public health units, as you know, or in partnership with various community partners. With modernized standards, we're looking at making more transparent data available.

The Chair (Ms. Cheri DiNovo): I'm afraid you're going to have to leave it there. We now move to the government side. Ms. Kiwala.

Ms. Sophie Kiwala: Thank you very much for being here. I would like to talk a little bit about capital projects. I'm sure that will come as no surprise to you. I would like to start just by talking about some of the conditions that existed in Kingston General Hospital prior to our announcement there this past Friday. There's no doubt that there is a number of aging hospitals across the province, and it must be incredibly challenging to allocate and assess the projects that are in need of extra funding for the capital renovations. We're very proud of our hospital, despite some of the aging sections of it. As you know, some of those sections go back to 1925. It's quite substantial in terms of how much renovation is needed in many of the different parts.

We're very proud of many of the different sections of the hospital; in particular, the cardiac electrophysiology department. As you probably know, we had Dr. Ben Glover and Gianluigi Bisleri here with the CAHO hospitals just the other week, as well as Adrian Baranchuk, some very well-known cardiologists who are working in Kingston, at Kingston General Hospital.

There is no doubt there are sections of all of the hospitals, I'm sure, across this province, which are very well developed, state-of-the-art, and kept up to very good standards, but also some that are not. We're very, very proud of everything that we have in our hospitals, and very thankful and proud of, for example, Providence Care Hospital, another capital project that is quite a gem in our community and our region.

We're also, of course, very proud of the fact that within the cardiology unit, we were the first in Canada, I believe, to do the atrial fibrillation ventricular arrhythmia catheter ablation and device therapy.

Mr. Arthur Potts: Well said.

Interjection: Did you practise that?

Ms. Sophie Kiwala: I did practise that.

There is no doubt the human infrastructure we have is top of the line in Kingston and the Islands, in all of our hospitals—in our emergency wards, in Providence Care, Hotel Dieu and Kingston General Hospital—but we can't keep top-of-the-line people and staff and researchers to work with Queen's University if we don't have a top-of-the-line facility. I know you know that, and therefore I am very thankful for this recognition and investment in Kingston General Hospital just this last Friday. It means an incredible amount to my community.

1700

Given that the ministry is supporting these numerous health infrastructure projects around the province, can you give us an update on the projects themselves and discuss some of the key features of the ministry's investment in health infrastructure across the province?

Interjection.

Hon. Eric Hoskins: Yes. I'll actually give Peter an opportunity to speak. I was looking for the long list of hospital redevelopments that are taking place, but if I go through that you probably won't have much time at the end of it. This is such an important issue. We owe it to patients and clients and their families. We owe it to those hard-working, compassionate, excellent health care providers at all levels who work within our health care system that the infrastructure that they work with is of the highest quality possible.

You're pretty active in Kingston these days. Earlier this year, I was honoured to be at Providence Care for the grand opening of that brand new hospital—a major infrastructure investment by the province, by our ministry—and then of course last Friday the announcement for the redevelopment of the Kingston General Hospital site of the Kingston health sciences network, which is exciting. There was a lot of excitement that day because you've got the highest-calibre health care providers and specialists and workers. Everybody in the hospital, from the volunteers to the leadership, is so excited about what this is going to mean for their ability to provide care into the future for a big population, about half a million people, that depends on it in the Kingston region.

Truly, it has been exciting and, I'd have to say, somewhat exhausting. Peter, I'm sure, can appreciate this as well. It is unprecedented in this province's history, the level of funding that we're putting towards capital investments in our hospital infrastructure, in capital infrastructure for our health system; a $20-billion commitment over the next 10 years alone, which is tremendous.

Just a couple of days ago I was in Niagara unveiling the sign for the new south Niagara hospital, which will provide tremendous services, a state-of-the-art facility for the residents that depend on it, and, as a little sidebar, but an important one, also announcing the Welland hospital that I've been working closely with the mayor and others in the community on, and the local MPP, keeping that hospital open. I know that's not a capital investment, but there are elements of that that will no doubt require renovations and development.

Whether it's in Milton, where I was six or seven weeks ago for the opening of their new patient tower; or with the Premier in Burlington, just a few weeks ago as well, cutting the tape on the brand new infrastructure, a patient tower, at the hospital in Burlington; or the announcement that we made in the budget, the commitment for the Windsor Regional Hospital rebuild/redevelopment, a state-of-the-art hospital as well; in WAHA in the north as well, for the Weeneebayko Area Health Authority, a new hospital committed to in the budget; or Trillium Health Partners in Mississauga; or just last year or so, or maybe the year before, the opening of the brand new Oakville hospital as well; and the Humber River Hospital in Toronto, or the investment that's happening with Toronto East General, there are so many activities

going on across this province—Atikokan, as well, and Cambridge. We have, I think, about 35 hospitals that are either being built brand new or redeveloped or expanded or they're in some stage of getting to that point. With Scarborough and with Durham, that I referenced earlier, the planning grant for both those regions so that they can plan for what their future acute hospital needs are going to be—it's a very important part of the work that we do as a ministry, as you can appreciate, for the reasons that you know and that I referenced at the beginning. It's just to ensure that that environment is conducive to healing and conducive to the practice of health care, whether you're a PSW attending to somebody's needs or whether you're the most specialized surgeon doing the procedure that you described.

That's the commitment that we've made as a government. We enhanced that significantly in this year's budget, as I mentioned, so we're now at a $20-billion investment over a 10-year period. I'm just very proud of the work that the ministry has done. They know that, for all of the right reasons, I've pushed them very hard on these infrastructure projects, because they are so important. I am blessed, if you will, by having a ministry and particularly—but not solely; don't take this the wrong away, anybody—the capital and the infrastructure branch within the ministry.

It isn't just tasked with building new hospitals, I should add; they have a whole breadth of responsibilities. Peter and his team do an absolutely exceptional job at making sure that the money is effectively and efficiently invested, that the process is one where the community is maximally involved. We're listening to what the patient-client and family-caregiver needs are and respond to that, as well as to the needs and requirements of our health care providers themselves, and making sure that every step of the process is as transparent as possible, as efficient as possible and as effective as possible.

You see the result of his work and his team's hard work and the ministry's hard work: these tremendous edifices that are truly state of the art, and in many cases are the best in North America, if not beyond.

It's a big burden that—I think this came up the first time; I know it's my burden ultimately, but I'd delegate a portion of that to my very talented officials.

With that, I'm going to let Peter maybe describe—how many minutes do I have left?

The Chair (Ms. Cheri DiNovo): Just under 10.

Hon. Eric Hoskins: Peter, you have just under 10 minutes to explore this a little bit more. Thank you.

Ms. Sophie Kiwala: Just before you move on, we had a conversation—we talked about wait times. One of the issues at Kingston General Hospital was that one of their operating rooms had to be closed down, because the HVAC system was insufficient to keep the air circulating at a high enough level. That's one example where wait times are going to be very improved with this infrastructure spending. I think it's worth noting that it's not just about changing old to new; it is about the patient. It is about the end use. I just wanted to add that. Go ahead.

Mr. Peter Kaftarian: Thank you. Hi. Peter Kaftarian. I'm the assistant deputy minister of the health capital division in the Ministry of Health and Long-Term Care.

Thank you for your comments, Minister. I do provide the leadership and strategic oversight of our infrastructure portfolio and lead a great team of professionals who help move forward all of the projects that we're working on. Our vision in our division is to help build quality facilities to support the delivery of excellent health care to the people of Ontario, and that's what we work on every day.

We do have two key areas within the division, and my responsibility is the health capital investment branch, which focuses on hospital, community and public health capital projects, and also the long-term-care-home renewal branch, which is responsible for the redevelopment of long-term-care homes as well.

We do have, as the minister mentioned, approximately 35 major hospital projects on the go that are in various stages of planning. The province does have a $20-billion commitment over the next 10 years for hospital infrastructure. We're very pleased to be moving forward as quickly as we can on many of these projects.

Not only in hospitals, but in the 2014 budget, there was a commitment to put new funding of $300 million over the next 10 years to support the shift of services from hospitals into community. We made a lot of changes in our community program and put together, through extensive consultation with the sector, a streamlined community funding policy that does align with the Premier's adviser on community hubs—the work that Karen Pitre is doing. We've made a lot of changes to our process to relax the prescriptive elements of our program and allow more creativity to bring different service providers under one roof.

1710

As we also know, we have our growing, aging population. We know there's demand on the hospitals. We know where there's high growth. We know where there's need, and some of these projects are going to help establish that. Our average hospital age is 47 years old. We have new hospitals, we have old ones, but our average age is 47, so we do have a lot of infrastructure needs.

We really keep a focus on both a patients-first and a residents-first perspective, whether it's in hospitals or in long-term-care homes, as we move forward with significant investments.

I'm conscious of time.

In addition to our major hospital program, which are projects over $10 million, or our small hospital program, which would be projects under $10 million, we have our Enhanced Long-Term Care Home Renewal Strategy that I'll talk a bit about. We also have our HIRF program. I know we've had questions before at this committee; it's the Health Infrastructure Renewal Fund. We've made significant investments in this program over the past four or five years. This money fixes things like, if we're not able to build or do a renovation on a big hospital project, roofs, windows, heating, HVAC, fire alarms, backup

generators. We do this through an evidence-based system, but we've grown this program to $175 million annually. I think three or four years ago, it was $56 million, but we made the business case on the need to invest in hospitals. It's become a very successful program. We do our best to roll out the funding as early as we can in the fiscal year to give the hospitals the maximum amount of time to get these projects done.

We've also introduced an exceptional circumstance process for hospitals where, through the formulaic process, if they're unable to get as much money as they would like, from that perspective, they can put a business case in through the LHIN, and we're able to allocate HIRF dollars for additional projects as well. That has proven to be very successful and has allowed us to target even more projects that are obviously high-priority needs in the hospitals.

Under our community health capital policy program, we released a new program in December 2015. We're very excited about the change. We are working through some historical approvals as well as new approvals to get these projects moving forward. There are obviously some complexities with partner space, but we really feel like we've listened to the sector. We've recently made updates to our policies to allow for more things to happen within this funding, whether it's a community health centre, family health team or community-based mental health and addiction program. We're excited about the progress we made on this policy.

An example of flexibility in our program would be the Carlington Community Health Hub. This is a partnership between the CCHC and Ottawa Community Housing, which brought together affordable housing for seniors as well as primary medical care and support for services under one roof. This was a challenging project to work through, but we're making it happen. It's well under way.

We also released the CIRF program. We have our HIRF program; we now have a CIRF, Community Infrastructure Renewal Fund. We rolled it out last year. This is our second year. This provided infrastructure funding for minor projects in community organizations: 59 community-based providers in the last fiscal year received $4.1 million; this year we approved $7.3 million and 68 providers received funding. This has been well received, so we now have the equivalent of our HIRF projects in the community sector, which was a request for a long time, because there was no program to tap into for infrastructure dollars.

Our work doesn't stop in hospitals and community. Long-term-care redevelopment is another key area of responsibility that I'm leading the charge on with a really great team. We have 78,000 long-term-care beds in the province over 600 homes, and there are approximately 300 of these long-term-care homes that need to redevelop to current design standards by 2025.

Between October 2003 and October 2017, there have been more than 10,000 beds developed and 13,500 redeveloped. We're now focusing on this next batch of 30,000 beds. In October 2014, we announced enhancements to the redevelopment program. We had extensive stakeholder consultation for a few months after that announcement to ensure we were doing the most we could to make the program work. We made changes by establishing a branch; we set up a brand new branch within the ministry where their sole focus is on redeveloping long-term-care homes. We have increased the subsidy provided to operators by just under $5. We've added the ability for long-term-care homes to extend their licence from 25 to 30 years. We've put a variance request process in, so if long-term-care home operators are, for example, landlocked and they can't extend their building or build on a bigger footprint, they can come to the ministry and request consideration for a variance to an element of our design manual that would enable them to redevelop.

The Chair (Ms. Cheri DiNovo): You have under two minutes left.

Mr. Peter Kaftarian: Thank you.

Successfully moving forward on this program, we did announce the Grove, Arnprior and District Nursing Home receiving an additional 36 beds back in August, when it went from 60 to 96 beds. This home is approved for redevelopment. It's going to be more modern, comfortable and as home-like as possible.

We have made great progress on our program when it comes to applications. Just under 100 homes have submitted an application for redevelopment. It's closing in on 12,000 to close to 13,000 beds for redevelopment. We're doing our best to move these projects forward as quickly as we can.

We do have a construction-funding subsidy. It's a bit different than our hospital community program. We don't pay back the long-term-care operator until the project is built and they're actually admitting residents to the home. The subsidy is paid out over a 25-year period. My operation is responsible for ensuring that the building is built to our very specific design requirements before the operator is allowed to open the home and admit residents. So that's another area of our program.

Ms. Sophie Kiwala: I just wanted to add that another investment in Kingston that I've been very appreciative of, and it's extremely important at this point in time, is the Street Health harm reduction centre. That's another area that hasn't been touched on. It's certainly an area, with the growing opioid crisis, that is very much appreciated in our community—

The Chair (Ms. Cheri DiNovo): I'm afraid that is time.

We now move to the official opposition. Mr. Yurek.

Mr. Jeff Yurek: Minister, how much did the ministry spend in 2016-17 on out-of-country prior-approved services?

Hon. Eric Hoskins: The deputy might have it before me, but we'll have it in a moment, I think.

Mr. Jeff Yurek: Maybe you can answer the second half. How was that budget determined?

Dr. Bob Bell: In general, patients who are eligible for OHIP are eligible for out-of-country referral if a provider in Ontario recommends them for treatment that's not

available here. For certain areas, like cancer care, we have established referral programs set up where Cancer Care Ontario assigns specialists who evaluate whether care is appropriate. We do not provide funding for care out of province or out of country that is experimental in nature. But if a treatment is considered to be medically necessary and is not available within the province, patients are sent out of country.

The actual amount spent in the last few years—

Hon. Eric Hoskins: For—

Dr. Bob Bell: Please go ahead, Minister.

Hon. Eric Hoskins: Sorry, Deputy. For 2016-17, the actuals for out-of-country were $92.5 million.

Dr. Bob Bell: The program was, again, an open-ended program. This year our estimates were that $57.6 million would be used for out-of-country referrals and, as you see, last year we exceeded that.

Mr. Jeff Yurek: In coming up with that estimate, what are you basing that on?

Dr. Bob Bell: If we look at actuals from 2015-16 and 2014-15, we were closer to the 2017-18 estimates. That's based on historical performance. We've also spent quite a bit of money in the past on genetic testing being sent out of province, out of country. We've been managing to repatriate some of that testing into the province. So some of the reason for not showing an increase in the 2017-18 estimates relates to the fact that we're expecting fewer out-of-province genetic testing referrals.

Mr. Jeff Yurek: In 2016-17, how many applications were received for out-of-country prior-approved services, and how many were approved?

Hon. Eric Hoskins: I'm not sure if that is in anyone's notes. The last year—I have my House book note, which isn't dated, but I assume it's up to date. It says, "Last year, the ministry approved 16,223 out-of-country; 96% of applicants were approved." Again, I think what the deputy said is important: that we leave it to clinical experts to provide the recommendation with regard to it being both OHIP-eligible but also a recommended procedure by clinical experts.

1720

Mr. Jeff Yurek: What was spent in 2016-17 on out-of-country emergency services for travellers?

Dr. Bob Bell: I'm not sure that we've got anything on that.

Hon. Eric Hoskins: So this would be individuals who are travelling abroad who may or may not have insurance and then apply for a partial reimbursement from the province?

Mr. Jeff Yurek: Yes.

Hon. Eric Hoskins: Okay. I'm not sure if we have—is there anybody who might have that information? I'm seeing a lot of heads doing this.

Mr. Jeff Yurek: I'll let them dig around for that.

How much money has been paid to Think Research over the last five years?

Mr. Gilles Bisson: Research?

Mr. Jeff Yurek: Think Research.

Mr. Gilles Bisson: Oh, Think Research.

Hon. Eric Hoskins: I don't have that information before me. I would be happy to talk to the ministry to see.

Mr. Jeff Yurek: Okay. So you will submit that to committee, if possible.

Has the ministry completed an economic analysis of the federal government's proposed tax changes to Ontario's registered health professions?

Dr. Bob Bell: As you know, the small-business tax changes that have been proposed have had significant changes recently. We have done some analysis of the impact of the change related to both income sprinkling and the changes in taxation of passive income within incorporated physicians' corporations. But these have changed recently, and the initial analysis that we did probably needs to be repeated and is being repeated.

Mr. Jeff Yurek: Through your analysis, do you think this will affect your ability to reach a deal with our doctors?

Hon. Eric Hoskins: I can speak to that. I'm absolutely confident that we're going to reach an agreement with the OMA on behalf of Ontario's doctors.

I would just say, with respect, with regard to any proposed changes by the federal government emanating from the Ministry of Finance, that it's probably out of the purview of the Ministry of Health of Ontario. The question would be better asked of the Minister of Finance of Ontario.

Mr. Jeff Yurek: The Association of Ontario Health Centres says that most members haven't received a base operating budget since 2012, despite the cost of operations going up over 7% in the last five years. We all know CHCs provide health care to some of the province's most marginalized and vulnerable, and some members are having to cut programs and services or lay off staff. Are there plans in the 2018-19 budget to fund increased operation pressures for CHCs?

Hon. Eric Hoskins: Perhaps the deputy or staff can speak in more detail, but with regard to certain human-resource individuals or the interdisciplinary team, both last year and this year, we have increased the compensation of, for example, nurse practitioners, dietitians, occupational therapists and others who work in our community health centres.

That was a priority of the government. Our aim was to close the gap between those professionals working, for example, in the CHCs and in hospitals and other environments. We've certainly made a significant investment into our CHCs in that regard.

It may be the deputy has more specific information in terms of your request.

Dr. Bob Bell: Yes, in terms of the recruitment and retention funding that we've provided to various interprofessional care providers within primary care models, including CHCs and aboriginal health access centres, there was an $85-million commitment over three years made in the 2016 budget and a further $145-million commitment over three years made in the 2017 budget. The rollout total for recruitment and retention: 2016-17,

$22.2 million; 2017-18, $56.3 million in total; 2018-19, $80.4 million; and in 2019-20, $104.7 million planned. A planning guide has been developed to provide guidance on salary levels that we use to determine various recipients' allocations as a result of this funding.

Mr. Jeff Yurek: Are there any plans in the 2018-19 budget to provide the promised capital funding to the 35 CHCs and aboriginal health access centres to expand current sites and move into new sites?

Dr. Bob Bell: I'm going to ask Sharon Lee Smith to come up—is she still here?

In the Ontario First Nations action plan, we have a commitment to 10 new primary care sites across the province. We're just in the process of completion of discussions with indigenous communities around the kinds of models of primary care they think are appropriate. But there is no question that some of these, if not many of these, will be aboriginal health access centres, which as you know are very successful in providing primary care.

Sharon Lee, maybe you can speak to where we're at.

Ms. Sharon Lee Smith: I can absolutely speak to it, and we also have our—

Interjection.

Ms. Sharon Lee Smith: Sharon Lee Smith, associate deputy minister for policy and transformation. We have our director of primary care here as well.

I'm very happy to say that, in the Ontario First Nations action plan, we had allocated a specific amount for up to 10—in and around 10—brand new primary care centres for First Nations people, for indigenous people. We have gone quite far to have the work and the design of those centres—we also wanted to make sure, in doing the design, that we were working with Chiefs of Ontario and other First Nations to get their input about how best to do it and how best to be very inclusive in our thinking and also doing things like, to the best of our ability, building on our aboriginal health access centres and the good work they're doing, but deviating, maybe looking at other areas, if an AHAC wasn't available.

We are just coming to the conclusion of that work, and we have not gone forward with communicating where they're going to go. Phil, am I saying everything properly?

Interjection: Yes, you are.

Ms. Sharon Lee Smith: It's just because we're doing the internal due diligence in making sure that our partners are with us. We did not want to have a system where we were deciding where the primary care centres would go. We wanted to be inclusive. We are kind of torqueing north, if you will—more in the north than in the south—but looking across the province. We are probably the only jurisdiction, aside from BC, that is getting into this space about really trying to strengthen primary care.

Dr. Bob Bell: Sharon Lee, if I may?

I was just provided with the answer to the question you had: We have six projects related to the capital expansion of the AHAC provider centres. Those are under planning currently.

Mr. Jeff Yurek: Okay. Thank you.

Page 128 of the estimates lists an $8-million investment in regard to vaccinations. Could you explain to the committee why pharmacists were excluded from the list of health care practitioners who could administer the publicly funded shingles vaccine?

Ms. Roselle Martino: Roselle Martino, assistant deputy minister of population and public health. I believe that the ministry and minister continue to look at opportunities for pharmacists.

1730

The reason for the publicly funded shingles program is because it's a schedule 1 drug. When a vaccine is publicly funded, there's a certain amount that's available to all of our delivery agents. In this case, it would be available to all primary care providers, and they would have a supply on hand; that's how publicly funded programs work for vaccines.

Because it was a schedule 1 drug, a patient would have to go to their doctor. If they wanted to get it from their primary care provider, they could get it right then and there, because it would be available as part of a publicly funded program. If they had to go to a pharmacist, they would have to get a prescription from the doctor or their primary care provider and then go and get the pharmacist to administer it. So it was a two-pronged trip for the patient or client, and we were trying to reduce that burden on anybody. They could it get it right then and there.

I think the minister is looking at different opportunities to include pharmacists as part of all of our vaccination programs.

Mr. Jeff Yurek: The distribution of the Ontario health premium shifted in 2016-17 so that revenue for hospitals, OHIP, home care, community and mental health services, long-term-care homes in Ontario and drug programs decreased for an increase to the revenue to public health, health promotion and other. Can you explain why that happened?

Hon. Eric Hoskins: I'm going to need some help on that.

Dr. Bob Bell: Yes. Could you just go over that again, Mr. Yurek? Apologies.

Mr. Jeff Yurek: Sure. The distribution of the Ontario health premium shifted in 2016-17 so that revenue for hospitals, OHIP, home care, community and mental health services, long-term-care homes and drug programs decreased for an increase to the revenue to public health, health promotion and others. Can you explain what occurred or why?

Dr. Bob Bell: I'll take a stab at it. My understanding is the Ontario health premium doesn't get designated toward any specific element, so the budget is simply included in the overall health budget.

Hon. Eric Hoskins: Yes, and with respect, I believe that's probably out of scope for our ministry. It's a question that would be better and more appropriately answered by finance.

Mr. Jeff Yurek: You're making me come back for estimates for finance? Is that—

Hon. Eric Hoskins: I'm sure you can't wait.

Mr. Jeff Yurek: Yes. Charles would love it.

The 2017 budget indicated that the government would be exploring a voucher demonstration project to help seniors find accommodation outside of hospitals while waiting for long-term-care homes. Could you give us a status update?

Dr. Bob Bell: I'll take a stab at that. This is a very specific situation where a patient who might be able to benefit from the rehabilitation transitional services that I described earlier might have access to a privately funded retirement home bed, as an example, and might not have the fiscal capacity to pay for that. In that situation, there's consideration for possibly providing that individual with a voucher to help offset the cost of a retirement bed. This is a very early-stage program that hasn't been started as of yet.

Why don't you come and join me, Patrick?

We're using learnings from the seniors' supportive housing program to help us understand the patients who might be eligible for this kind of program and basically expanding these transitional care models to a variety of different environments where care can be provided by home care when the patient needs more stable housing than is available to them at home. An example might be a patient who is living in a three-storey house. Where we can't provide safe home care across the three storeys of their house, we're bringing them to a retirement model, for example, or a supportive housing placement for a period of time while we provide them with rehabilitation services through home care. This is something that we're thinking a voucher model might be appropriate for.

The Chair (Ms. Cheri DiNovo): Mr. Yurek, you have two minutes.

Mr. Jeff Yurek: Thank you. When can we expect the funding to flow for the redevelopment of all 963 long-term-care beds you've committed to?

Dr. Bob Bell: We have a commitment to many more redevelopment projects. I think the total is 30,000, but—

Hon. Eric Hoskins: Maybe the officials have a better—do you have a better sense? I'm just not sure which 963 you're referring to. I think you know that since coming into office in 2003, we've redeveloped 13,500 beds thus far. We have a commitment to redevelop 30,000 by 2025. We're obviously well on our way. It's an ongoing process, and it's a multi-stage process as well. Do you have a sense of what the 963 are?

Dr. Bob Bell: Yes, I think these were referenced in the budget. Yes. So the construction subsidy that is paid is initiated at a per diem basis once the home is operational once their redevelopment has been completed. I believe that's usually about a two-year process, so those beds would start to require increased funding about two years following the start of their redevelopment process.

Mr. Jeff Yurek: How much time?

The Chair (Ms. Cheri DiNovo): Twenty seconds.

Mr. Jeff Yurek: It's been a pleasure this afternoon.

Hon. Eric Hoskins: Yes, likewise.

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

Mr. Gilles Bisson: I've got a couple of questions. I know our critic, France Gélinas from Nickel Belt, has got a bunch more, but I wanted to come here and ask a couple of questions.

I'm going to be parochial here. Minister, you will know that we discussed the whole ambulance issue in regard to the transfer of patients, and I thank you for helping to help us move this along a little bit. I'm aware, with the briefing that you provided with your staff, that we're going to be putting in place a transfer system on the Highway 11 corridor. I know all of that.

There is still an issue. You would have seen in the paper—I think it was yesterday in the Timmins Daily Press—Dr. George, who raised the issue of patients being stranded at the Matheson hospital and not being able to be transferred into the Timmins and District Hospital. I spoke to doctors on Highway 11 as well, yesterday and today, when I saw that article, just to see. They're saying it's a bit better, but part of the problem is the emergency ambulance services are triaging those people who are being referred by their physician. So you're the physician—as you are, good Minister—and you say, "That person's got to go over there" for whatever test or whatever needs to be done, and all of a sudden you're second-guessed by the paramedic, who says, "This is not life-threatening." And so the person is not transferred and then the hospital has to arrange their own transfer at their cost to move the patient.

It's a real problem—I'll just end on this point—when it comes to mental health services. If the person is a mental health patient, either juvenile or adult, they don't see it as threatening and they leave the patient in the local hospital.

Can we do something about that until we get to the point of actually putting a transfer system in place?

Hon. Eric Hoskins: This is an important question, and we have discussed this more than once. It's an issue that I find not only critical, but somewhat troubling as well.

I'm glad that you felt that the briefing provided by the ministry—

Mr. Gilles Bisson: It was helpful; it was very good.

Hon. Eric Hoskins: Yes, it was helpful and provided the details that you needed to at least see what the medium-term and long-term destination would be for improving this. But it's clear that there is work to be done. I certainly want clinicians to have the confidence, when they do refer a patient or a client for transfer, that that person will be safe and secure.

Perhaps Patricia Li from the ministry can provide some more specific details. I'm sure she can.

Ms. Patricia Li: Sure. Thank you. Patricia Li, Ministry of Health.

Mr. Gilles Bisson: I'm looking for the short explanation because I've got a couple of other questions. Sorry.

Ms. Patricia Li: Okay. Yes, I remember a couple of weeks ago we were able to brief you on the pilot project in northeastern Ontario—

Mr. Gilles Bisson: And I thank you for that.

Ms. Patricia Li: —and the ones that we are going to implement in the North West LHIN.

Mr. Gilles Bisson: North East.

Ms. Patricia Li: One of the things in the interim that—

Hon. Eric Hoskins: North East.

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Ms. Patricia Li: Sorry.

Mr. Gilles Bisson: No, no, go ahead.

Ms. Patricia Li: You wanted to know in the interim, right?

Mr. Gilles Bisson: Yes.

Ms. Patricia Li: What we are doing is, we are currently setting up a pilot in Middlesex-London particularly referring to patients of mental health. We just started it last week with a medical algorithm, which doesn't take us long, as a North East proposal. So we are running it for a couple of months just to see whether the medical algorithm works, because we just started it last week. If that works, we can certainly consider that solution in the interim before the North East's contract is set up for next year.

Mr. Gilles Bisson: But my problem is, until we get to the contract, we have mental health patients who are being stranded in hospitals that don't have the capacity to be able to deal with their mental health needs, and that, as we know, is dangerous. So my question is, where there is a bed available—and I've confirmed this; there is a bed available in the MHU in Timmins—you end up in a situation where the clinician says, "This person needs to go to the MHU," the bed is available, and the ambulance shows up and says, "Well, it's not life-threatening. This is not a medical issue." There seems to be a bit of a disconnect because it's a mental health issue, and I guess what I'm asking is that we don't second-guess the doctors. The doctors know what they've got to do. Let them do their job.

Hon. Eric Hoskins: Maybe I can jump in here as well. We know that urgent and non-urgent medical transport is important across the province, particularly so in the north; I agree with you on that. We believe that through the pilot in the North East LHIN we're going to have a better solution, with the understanding that it's going to take some time for that to evolve.

Because I agree with you that this is a critically important issue, we'll see if we can find in the interim, prior to that pilot, a solution that works, that has your confidence and that of clinicians as well. Maybe we can learn from the London example. It may be that we can actually implement a similar trial that would provide that support during the gap period.

Mr. Gilles Bisson: Maybe what I can do to be helpful is I'll get my staff, one of whom is right over here, Courtney, who's from Timmins—hello, Courtney; Say hello—to get some of the information from the doctors who I spoke to so that we can give it to you, and then you can understand and do what needs to be done.

Hon. Eric Hoskins: Yes. And it may be that the solution to this is easier than we imagine, right? I agree with you in terms of we have the same position on this: that this needs to be remedied as soon as possible.

Mr. Gilles Bisson: Second issue: You want to save $840,000?

Dr. Bob Bell: Always.

Mr. Gilles Bisson: Okay. Here's the problem: The pot comes from the same person, you and I. We're the taxpayer; we pay the money. The problem is, you have a hospital budget, you have an OHIP budget, you have a northern travel grant budget. The twain will never meet, as we well know. This is not a problem that you've created; this is a problem that's been around a long time.

Interjection.

Mr. Gilles Bisson: This is the sleep lab—exactly. I love how you figured it out.

The sleep lab in Timmins was originally set up as a cost-neutral service to the hospital, because the hospital said, "Okay, you can put it in our hospital. We'll provide it. It's a service we need in our community." Unfortunately, OHIP is not covering some of the stuff that it used to cover before, so they're having to absorb $160,000 a year to run the sleep lab.

As you know, our hospitals are having difficulty balancing. They're $1 million short this year, even with the 2.7% increase that they got. The issue is, to save $160,000 in the TDH hospital, we're going to shut the sleep lab down, if you give them permission. we're going to send the patients to Sudbury, we're going to pay them the northern travel grant—and I've had somebody calculate it who knows what this is all about. It's a million bucks. We're going to spend a million bucks to save $160,000.

Can you help me merge the two together so OHIP can do what it's got to do and we keep our sleep lab open?

Hon. Eric Hoskins: Yes. My understanding is that we're looking into this, but my belief and my understanding is that we haven't changed the nature of the funding. It may be that the costs of accommodating the lab within the hospital premises have changed—

Mr. Gilles Bisson: Yes, the problem, as I understand it in speaking to the hospital, is, there are some things that are now required that weren't required under the old OHIP billing. The OHIP billing, as it was set up, said, "Here's the work that needs to be done," and then now there's a new norm of what needs to be done, and it involves more time and it's not covered by the billing.

Dr. Bob Bell: I know this area reasonably well. I'm not aware of any change in requirement that we've had. It's possible the providers may have asked for more forms of monitoring for the sleep labs. We're actually currently looking into this, why the hospital has decided to think about discontinuing the service, so we will let you know.

Hon. Eric Hoskins: We're on it.

Mr. Gilles Bisson: All right. So the whole idea is that I don't want to have people from Hearst and Timmins have to go to Sudbury. I love Sudbury. My good friend France Gélinas, I love your community, but we don't need to go to Sudbury to get that service. We used to have it at home.

Hon. Eric Hoskins: Yes, we share that concern, so we're looking into it.

Mr. Gilles Bisson: I have to ask you this question. I've been a member for 28 years now. Centre de santé communautaire de Timmins: We've been working on that sucker for the last 28 years. We had it going at one point. Unfortunately, when you guys became the government, you closed down the process—I've got to blame the Tories here. It's just a little shot that I have to do. Sorry about that.

Mr. Jeff Yurek: Everybody does. We're thick-skinned.

Mr. Gilles Bisson: That's all right.

I know that the LHIN has supported the application to move towards a francophone health centre in Timmins. I know that they're actively working with the community in order to do something to get it up. I think, in fact, that tonight there is a meeting with the LHIN and l'Alliance de la francophonie de Timmins and others, as I understand it—

Mme France Gélinas: You've been doing this for 28 years?

Mr. Gilles Bisson: Twenty-eight years. Could we please deliver this thing, once and for all? The city of Timmins is probably the only major francophone centre that doesn't have a francophone health centre. Can you deliver, please?

Hon. Eric Hoskins: I can tell you what we've done already. I had a meeting, I think, earlier this year with a member of the committee—

Mr. Gilles Bisson: Yes, you and I did, with Monsieur Bélanger.

Hon. Eric Hoskins: Yes, thank you—and I expressed my—

Mr. Gilles Bisson: And he wants to come back.

Hon. Eric Hoskins: Perhaps he should. I'd be happy to see him. At that time, I expressed my strong support for the work that has been done—

Mr. Gilles Bisson: And that helped, because it moved things along.

Hon. Eric Hoskins: In fact, shortly thereafter, I believe we announced a planning grant that the committee, in concert with the LHIN, would then further develop what the plan would be. My understanding is that we're waiting to hear back from the North East LHIN on the results of that planning grant and what their specific proposal is. But we're very amenable to it and look forward to receiving the results of that planning grant.

Mr. Gilles Bisson: I will be bringing him back, just so you know. Stay tuned.

Hon. Eric Hoskins: Tell him to bring the results with him.

Mr. Gilles Bisson: And I end on this 30-second note: Thanks on the Attawapiskat clean-up issue. You guys did a bang-up job. We shut down a school in Attawapiskat under the federal government; it took 20 years to rebuild. We had a spill in that hospital; we cleaned it in about eight months.

Hon. Eric Hoskins: But do you know how we did it? It's because we did it together.

Mr. Gilles Bisson: Yes, yes, I know. It was a good thing. That was good. I just have to say.

Dr. Bob Bell: I appreciate it.

The Chair (Ms. Cheri DiNovo): Madame Gélinas.

Mme France Gélinas: I'm thrilled—

Mr. Gilles Bisson: But I will attack you on other things, just so you know.

Laughter.

Hon. Eric Hoskins: I know.

Mr. Gilles Bisson: As a matter of fact, I've got a question coming tomorrow.

The Chair (Ms. Cheri DiNovo): Madame Gélinas.

Mme France Gélinas: I'm very happy to hear that Timmins may finally be getting their francophone community health centre. There are a number of other communities that have been asking for a community health centre for a long period of time. Are there targets, objectives or something? Can we expect a specific number to be also funded, or does everybody need to have Gilles as their MPP so they can get a new community health centre?

Hon. Eric Hoskins: I expect that officials can speak to this, or perhaps the deputy as well. I think that we've got 75 community health centres across the province; we may have 76 soon. It goes without saying that they're such a tremendous and valuable resource for the community. But with regard to future plans, Deputy, can you speak to this?

Dr. Bob Bell: Thanks, Minister. Yes, we have a commitment of $15 million for 2017-18 and $43 million for 2018-19 for expansion of community health centres as part of our primary care expansion. The goal is to try and expand services without expanding administrative costs. The best way to do that is to use a satellite model, where we would expand services across sites while maintaining one administrative centre. I think that's what we're trying to do wherever possible. We're currently looking to see how much of the expansion we can achieve with these investments.

Mme France Gélinas: How many will be expanding this year? How many will be receiving money in the 2017-18 budget year?

Dr. Bob Bell: I can't tell you the number of CHCs. I think that's still in the planning stage.

Mr. Gilles Bisson: I think it says "Timmins."

Dr. Bob Bell: I'll introduce you to the director, Phil Graham, from our primary care branch, if I may, Minister.

Mr. Phil Graham: Hi. I'm Phil Graham, director of primary care for the Ministry of Health. Thanks for the question.

There is no target committed in terms of the number of CHCs or other interprofessional primary care teams. The approach is to look at communities or LHIN sub-regions that have an identified need and a lack of primary care capacity and working with the LHINs to put together plans on what model is best to fit that community need.

That could involve a satellite of a community health centre or a family health team or a new entity, but, to the deputy's point, limiting the administrative costs associated with that.

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M^me^ France Gélinas: So AHACs, nurse practitioners, community health centres and FHTs can all bid on that $15 million that you've announced?

Mr. Phil Graham: Yes, if they're in a region that has been identified as a priority. It's not so much an open expression of interest, as we've done in the past; it's working closely with the LHIN to identify the best model that's appropriate, based on the need in that region.

M^me^ France Gélinas: Except for the four models that I've named, are there other models that you would consider?

Mr. Phil Graham: Yes.

M^me^ France Gélinas: Such as?

Mr. Phil Graham: Things for which there are no names. We have four main primary care models. You know them well; you've just referenced them. There may be hub models where it's less of a formal corporate entity, like a community health centre or a nurse-practitioner-led clinic. It may be a pool of allied health professionals that could be available to support patients of a variety of different models. I think the main focus would likely be those four main interprofessional models that we have.

M^me^ France Gélinas: Okay. Let's say you're looking at an area of my riding that basically has nothing, except that we do have a community mental health sub-office that works quite well. Could we look at putting one or two nurse practitioners in such a thing, in community mental health, calling this access to primary care and have access to that $15 million, or am I too far off the path?

Mr. Phil Graham: That would be appropriate, in terms of the planning and the submission that the LHIN would make. We would look at that.

I think the key criterion is to ensure that what is being proposed meets the needs identified in that community. If it is an acute mental health need, for example, that needs some additional primary care capacity, it sounds like it might be a good solution. We're not limiting ourselves to those four models. We're going a bit broader to make sure that the model being proposed is commensurate with the need.

Dr. Bob Bell: You mentioned AHACs, Madame Gélinas. This is in addition to the 10 incremental primary care models for First Nations communities that Sharon Lee referenced earlier. It is quite an expansion of primary care.

M^me^ France Gélinas: So the 10 AHACs that you talked about earlier—

Dr. Bob Bell: Ten primary care models that may or may not be AHACs.

Mr. Phil Graham: Indigenous-governed primary care models, yes.

M^me^ France Gélinas: The 10 indigenous-governed primary care models—do we have targeted operating funds for them? Are we talking $1 million, $2 million operating money for them?

Interjection.

Mr. Phil Graham: Yes, I have it.

Dr. Bob Bell: You've got it? Good.

Mr. Phil Graham: Would you like me to respond?

Dr. Bob Bell: Please.

Mr. Phil Graham: Under the Ontario First Nations Health Action Plan, a total of $30 million was committed. That comes into place in 2018-19. That is to support up to 10 new indigenous-governed primary care teams.

M^me^ France Gélinas: So about $3 million in operating funds. Those are not capital?

Mr. Phil Graham: Not capital. Our focus is on operating right now, and we'll work with the successful groups to identify their capital needs.

M^me^ France Gélinas: Okay—how long?

The Chair (Ms. Cheri DiNovo): Just under four minutes.

M^me^ France Gélinas: Very quickly, I have a number of clients in my riding who, basically, used to be on—I don't know how to pronounce this medication—nabilone. N-A-B-I-L-O-N-E. It's covered by the formulary. They pay $2 and voila. Somehow, the specific prescriptions could not be filled and therefore their physicians switched them to cannabis. So they went through the thing, got their cannabis prescription. They are left to themselves to figure out how much they need, how to use this, and they have to pay full price, which ends up to be about $10 a gram, plus shipping, plus tax, with none of this being covered. Am I the only area that's facing that switch from something that is on the formulary to something that is not?

Hon. Eric Hoskins: You're talking about medical cannabis?

M^me^ France Gélinas: Yes.

Hon. Eric Hoskins: Which is federally regulated, as you know, and it is not part of the Ontario drug formulary; I don't believe it is part.

M^me^ France Gélinas: No, it's not.

Hon. Eric Hoskins: Is it part of the formularies anywhere in Canada?

Interjection: No.

M^me^ France Gélinas: Just for military.

Hon. Eric Hoskins: Okay.

Ms. Suzanne McGurn: Madame Gélinas, thank you for the question.

The Chair (Ms. Cheri DiNovo): Could you introduce yourself?

Ms. Suzanne McGurn: My apologies. Suzanne McGurn. I'm the executive officer for the Ontario Public Drug Programs. A shortage of the product that you're speaking of was identified to us late last week, and we have been in the process of making other products available as an alternative for individuals that would be covered through the formulary. I don't have the specifics in front of me but certainly can get back to you with that information. It is being communicated out, and we are

looking for how we can do that in a way that is least disruptive for clinicians and patients.

Mme France Gélinas: Do you have a time frame for this to happen?

Ms. Suzanne McGurn: Yes—immediately. I just don't have the specifics in front of me.

Mme France Gélinas: Okay. The second question is, I have a whole bunch of people who—this man had diagnostic schizophrenia, bipolar and severe anxiety, was on a whole bunch of medications and has now been switched to medical cannabis. He's on ODSP. He gets $860 a month. He pays $460 a month for his cannabis and $200 for his rent; that leaves him $200 to live on. His question is, when he was on all of the drugs he used, they were all paid for; he could afford them. They did not work. He writes to me and he says, "I have never been healthier mentally or physically in my entire life," but now he can't afford it.

Hon. Eric Hoskins: Presumably it was a clinical decision by his health care provider to switch him from his previous medications to medicinal cannabis, and presumably his practitioner at the time explained to him about medical cannabis, which is federally regulated but is not on the Ontario drug formulary, so it isn't currently covered by any of our drug programs, and we currently have no plans to change that. I'm gratified that he's improved as significantly as he has, but the current state, which is consistent across the country, as I understand it, is that medicinal cannabis, although federally regulated, is not covered by provincial or territorial drug programs.

The Chair (Ms. Cheri DiNovo): I'm sorry. We are finished at that point. Thank you.

We have less than three minutes. We now move to the government side. Madame Des Rosiers.

Mme Nathalie Des Rosiers: Yes. I'm very interested, actually, in the organ donation system that we have. I have to say, my interest in this question comes a little bit from having had the opportunity in a previous life of setting up in the Loeb organ donation chair at the University of Ottawa, whose mandate was, very interestingly, to look at the legal, ethical and governance issues surrounding organ donation.

Certainly, we know that it's an issue in terms of ensuring that people actually want to donate their organs. A long time ago, the law reform commission which I was on decided that it was appropriate, in light of our values, to not presume that people wanted to give and to demand that they actually express some interest or some commitment. It went back to the issue that our body is not for sale, our body belongs to us and the dignity of the person; they should express himself or herself in deciding which parts of his or her body should be given to science.

It was interesting for me to see the impact of that legal law reform decision translate several years later into, how do we then convince people that it's a good idea, it's good for the system and it's the right thing to do?

We had here at estimates a very interesting presentation by the Treasury Board Secretariat that explained to us that they have a little research unit that looked at how the way in which, and the time at which, the form for organ donation was presented when you go to ServiceOntario had an impact on the take-up; that is, if the form was presented as people entered ServiceOntario, they were more likely to fill it out right then and then sign up for organ donation, as opposed to our traditional way, which was to receive a form in the mail and be told that it would be a positive thing to do.

The Chair (Ms. Cheri DiNovo): I'm afraid time is up. This committee stands adjourned until November 14 at 9 a.m. here.

The committee adjourned at 1800.

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