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Tuesday 5 November 2013

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Mardi 5 novembre 2013

Standing Committee on Estimates

Ministry of Health
and Long-Term Care

Ministry of Transportation

Comité permanent des budgets des dépenses

Ministère de la Santé
et des Soins de longue durée

Ministère des Transports

Chair: Michael Prue
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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON ESTIMATES

COMITÉ PERMANENT DES BUDGETS DES DÉPENSES

Tuesday 5 November 2013

Mardi 5 novembre 2013

The committee met at 0901 in room 151.

MINISTRY OF HEALTH AND LONG-TERM CARE

The Chair (Mr. Michael Prue): We'll call the meeting to order. We are here to resume consideration of the estimates of the Ministry of Health and Long-Term Care. There is a total of exactly three hours remaining. When the committee was adjourned, the third party had 11 minutes remaining in its rotation.

Before we do that, I think, though, we need to put on the record happy birthday, Madam Minister. Happy birthday to your parliamentary assistant as well.

Hon. Deborah Matthews: Thank you.

The Chair (Mr. Michael Prue): You both share a birthday, and there's lots of birthday pie for everybody here. So help yourselves.

Hon. Deborah Matthews: You know, I have an idea how we could celebrate—

The Chair (Mr. Michael Prue): Go for it.

Hon. Deborah Matthews: —and it wouldn't involve being here.

The Chair (Mr. Michael Prue): Oh, no, no. This is another day in paradise. This cannot be missed.

France Gélinas, it is your 11 minutes.

M^me^ France Gélinas: Well, I feel like I should sing Happy Birthday, but I'm really sick today so there's not going to be any singing. I'm not sure if my voice is going to do 11 minutes in a row, so I may have to have it in little chunks. So far, I have my Fisherman's Friend and my Halls; I'm fully equipped.

I'll start with kind of a one-off question that has to do with the health units. I have a tough time finding the amount of money that goes to the different envelopes for our health units as the total amount spent by your ministry. Is this something that, I just don't know where to look for it, or is this something you could share with us?

Mr. Saäd Rafi: Public health units you mean?

M^me^ France Gélinas: Yes.

Mr. Saäd Rafi: Certainly, we can share it. It's cofunded with municipalities, as you know. So we can provide you the amount of funds that flow to the 36 public health units.

M^me^ France Gélinas: And I would like to know if the funds that flow to the health units flow by program area? Do you know how much money is going into, let's say, the Healthy Children initiative versus some of the other initiatives that the health units do. So I'm able to find the total amount you spend on health units; I'm looking for a breakdown as to some of the specific programs and services that they offer.

Mr. Saäd Rafi: It's my understanding that in certain cases we would have dedicated funding, so the discussion previously on Healthy Smiles and CINOT, and then I'm not certain if we are providing—because it comes from our public health division, the funding. So I think it's then sort of dispensed, if you will, or allocated by the health unit for the initiatives that they run in their health unit. I would want to be corrected, if necessary, on that, but we'll get you that information.

M^me^ France Gélinas: Okay. So if there is dedicated funding within the health units, what those amounts are, and otherwise, total amounts.

Mr. Saäd Rafi: Okay.

M^me^ France Gélinas: You still fund the health units directly? They don't go through the LHINs for any of their programs?

Mr. Saäd Rafi: Correct. That's my understanding.

M^me^ France Gélinas: So that was a one-off on health units.

Now I would like to spend a little bit of time talking about hospital funding. You've made it clear that hospitals are looking at a 0% base funding increase and you explained the HBAM and the changes in funding; I get all of this. What I'm trying to understand is, whenever I talk with hospitals, they always talk about what seem to be different pots of money that they receive their budgets from. When I look from year to year, some hospitals are getting budget increases, but then they have to explain to me, "Well, that comes from patient-based funding. That comes from the HBAM. That comes from the fact that we're a new hospital." My question is, how many different pots exist to fund our hospitals?

Mr. Saäd Rafi: First, holding the line on hospital growth spending is very true. Some hospitals will receive, under the activity-based funding model that we've put in place—this is the second year—additional funds; it's a function of efficiency. Some will be limited to the funds that they will not receive—in other words, perhaps a slight reduction—for that component.

Then, as you say, if there's a redevelopment in that hospital and the redevelopment has opened or it's a new hospital, they would get post-construction operating

funding, and that would be determined on a scaled-up basis, based on volumes that are taking place in that redeveloped facility or in that new hospital. They may also get provincial program funding, which is anything from wait-time monies or other individual procedures that are being funded on an activity-based approach, meaning that there's a reconciliation at year-end for how many volumes they did of that procedure or procedures. And there would be capital, if indeed they had a capital project.

Hon. Deborah Matthews: And the rural 1%.

Mr. Saäd Rafi: Oh, yes. For certain hospitals outside of the activity-based funding model—so rural and small hospitals—it would be a 1% increase, along with a $20-million fund for initiatives that they designed and delivered. There may be other sources that are just not coming to mind.

M^me^ France Gélinas: Okay.

Hon. Deborah Matthews: Just to add to that, we talk about a 0% base increase to hospitals. There is the additional funding on top of that, so overall, our hospital line is increasing by about 2%.

Mr. Saäd Rafi: Yes, that might be right.

Hon. Deborah Matthews: So there is more money going to hospitals, but it's not a base increase; it's attached, particularly, to volumes.

M^me^ France Gélinas: Okay.

Mr. Saäd Rafi: If I might—as we move to activity-based funding as a maturer way of funding, I think we have to move away from thinking about: Are you getting growth money or not getting growth money? You will grow, as it were, or you will continue to get volumes based on efficiency, effectiveness and where those volumes are allocated, which we will have to do with a planning exercise, which we haven't yet begun, and a capacity exercise.

M^me^ France Gélinas: Okay. When I talk to hospitals, sometimes they say, "We're 0%, but we've got ambulance offload nurses funding."

Mr. Saäd Rafi: Oh, sure.

Hon. Deborah Matthews: Yes.

M^me^ France Gélinas: What is that? I know what that is; the name says what it is. But I'm more interested in, is this part of the 2% growth that you say? If I look at the hospital line as a total, we can see that it's growing. How many of those different programs are there that exist out there?

Mr. Saäd Rafi: Yes. I think certain initiatives have come up as necessary. The example you use is a good one, actually, with respect to getting ambulances and their patients safely and securely into the emergency department to get them back on the road. That was an impact that was noticed; a response was provided through funding.

Some of those initiatives may be lasting; some may be for a time-limited period, and they may not exist in every hospital. We would have to sit down and get that list of initiatives and provincial programs and so on for you, the sources of funding for hospitals.

0910

M^me^ France Gélinas: Okay. I would appreciate that.

Hon. Deborah Matthews: And as we move to health system funding reform, so we move to more activity-based, population-based funding, we'll probably see less by way of things like PCOP because it'll be captured in the other funding streams.

M^me^ France Gélinas: Okay. And is patient-based funding going to be fully rolled out in three or four years?

Mr. Saäd Rafi: Four years.

M^me^ France Gélinas: In four years, okay. I thought it was three. Was there—

Hon. Deborah Matthews: It was initially.

M^me^ France Gélinas: It was initially three, now it's four. Okay. Is there any talk of multi-year funding for our hospitals after 2013-14?

Mr. Saäd Rafi: No. The province still participates and does a zero-based budgeting approach to all its funds.

M^me^ France Gélinas: Okay. So it's not something in—

Hon. Deborah Matthews: But having said that, hospitals do know where they would be if we had HSFR fully implemented. So we're mitigating the change—it's plus 3% or minus 1% this year—but hospitals know down the road whether they're going to be getting more money or less money under health system funding reform. So our ministry officials have taken a lot of time with each hospital, walking them through what the future holds for them.

M^me^ France Gélinas: For that piece of the pie that comes from health system funding reform—

Hon. Deborah Matthews: Which is up to 70%.

M^me^ France Gélinas: Depending on who you are.

Hon. Deborah Matthews: Yes.

Mr. Saäd Rafi: For 90 hospitals, it's 70%, yes.

M^me^ France Gélinas: All right. Another thing that I have a tough time finding, although your website works pretty well, is the number of beds in clinical areas, let's say as of—we'll put it as of September 1, 2013. We used to be able to find this. I'm not able to find that anymore. So if you look at the different clinical areas, whether it's obstetrics or—

Hon. Deborah Matthews: By hospital?

M^me^ France Gélinas: Not necessarily by hospital—province-wide.

Hon. Deborah Matthews: How many med-surg beds we have, how many—

M^me^ France Gélinas: Yes.

Hon. Deborah Matthews: That would change from day to day, right?

M^me^ France Gélinas: I don't know if it changes from day to day, but I used to be able to find that information. I'm not able to find it anymore.

Hon. Deborah Matthews: Okay. It looks like we might have—

Mr. Saäd Rafi: So there—

M^me^ France Gélinas: I'm not looking in the right spot?

Mr. Saäd Rafi: You're not looking for an answer? I'm sorry?

M^me^ France Gélinas: Yes, I am looking—

Mr. Saäd Rafi: Oh, sorry.

Hon. Deborah Matthews: She's not looking in the right spot, she said.

Mr. Saäd Rafi: At the risk of reading off something just handed to me, with that caveat, 2,100 bassinets—I didn't know that; 2,485 rehab beds; 5,547 chronic care beds; 4,813 mental health beds, which would be child, adolescent and adult; and 18,585 acute care beds. This is for fiscal year 2012-13.

The Chair (Mr. Michael Prue): I'm going to have to stop you there—

Hon. Deborah Matthews: And in addition, there would be long-term-care beds that aren't—this is just simply hospitals.

Mr. Saäd Rafi: Yes, just hospitals.

M^me^ France Gélinas: Okay.

The Chair (Mr. Michael Prue): On to the government. You now have 20 minutes. Ms. Jaczek.

Ms. Helena Jaczek: Thank you, Minister. We, on our previous round, were talking quite a bit about transformation. I think one of the difficulties in looking at the Ministry of Health and Long-Term Care—and this comes from some of my colleagues. This weekend, we celebrated the 40th year of our graduation from U of T medicine, so we had a great reunion. My classmates obviously follow ministry business as they are physicians in practice for the most part and many of them are heads of services and so on, obviously at our advanced age.

Anyway, they find a lot of the terminology quite difficult to get a handle on. I think the basic concept of moving from acute care to the community is understood, but we talk about transformation and we use acronyms and so on, and it can be quite puzzling for, I think, a lot of—so if it's puzzling for physicians to figure out exactly what's happening, it obviously can be quite puzzling for the general public. So I wanted to go into a little bit more about the kinds of broad changes that we're making.

One of the things that we were talking about last week was experience from other jurisdictions. I was wondering again if you could give some examples in terms of moving to the transformation—some specific examples from other jurisdictions that have worked particularly well and that we're modelling our changes on.

Hon. Deborah Matthews: Absolutely, and I'm going to invite Helen Angus to come up—she's our associate deputy responsible for transformation—because she may well want to add.

One country that we are very inspired by in terms of care for the elderly is Denmark. Denmark, back in the 1980s, decided not to build any more long-term-care beds, but they did decide, at the same time, to really enhance community supports, whether it was home care, supportive housing, hospice care—the full continuum of community supports. When you look at their spending on long-term care and community care, they actually spend more in community care than they do in long-term care. They have found that they are able to maintain the number of long-term-care beds that they have only if they invest heavily in the community sector.

That's been a pretty inspiring experience for us to follow, because the knee-jerk thing to do is to say that we have one long-term-care bed per however many people 80-plus and we need to continue with that ratio. We know now that we don't need to continue with that ratio. Yes, people will need care, and as the demographic shift is under way, we will have more people needing care, but do they need it in long-term-care homes? No, we're finding that they don't all. Many will, but the people who will be in long-term care will have much more complex conditions: advanced dementia, behavioural challenges and so on. But support in the community is the answer.

I'm going to turn it over to Helen, and she can speak in more detail about that.

Ms. Helen Angus: Yes, for sure. Thank you, Minister.

I would say we're in regular contact with jurisdictions like the UK and the National Health Service—in fact, twice this week. We're looking at our colleagues across the country that are implementing funding reform. As a practical matter, on funding reform we're one of the last jurisdictions to implement activity-based funding.

We're also, I think, in a position to teach some of our colleagues about our experiences in funding reform and particularly our work on health links. We've been looking with interest at some of the work on accountable care organizations in the United States that are looking at developing accountabilities for populations of patients and include hospital physicians and others.

I would say on the transformation that although there are lessons and parallels in many jurisdictions, as a practical matter, what we're trying to do in Ontario in terms of scope and scale is probably unprecedented, in trying to make as many changes on as many fronts in as big a system as the one in Ontario.

Mr. Saäd Rafi: I might add, if I could, that we would look very far afield; for example, the Shetty clinic or the Aravind eye centre, both out of India. Many people would say, "Well, there are different densities of population, obviously." Very true, but their unit cost and their outcomes—for example, in the Shetty clinic, $1,700 for complex cardiac surgery per patient, with outcomes as good as Texas or MIT. So they have a method that, then, is looking at an ambulatory—I'm not suggesting cardiac surgery should be ambulatory—an ambulatory clinic approach that is something I think we need to learn from.

So there are all manner of jurisdictions that one can take from for made-in-Ontario/made-for-Ontario solutions.

Ms. Helena Jaczek: How do prevention and health promotion fit into this transformation? I mean, as a former medical officer of health, we have been saying the same thing for many years, with certain successes and obviously requiring legislative change. I'm just thinking about Smoke-Free Ontario and so on, but all this activity that does occur in public health units, how are you bringing them into transformation?

Hon. Deborah Matthews: I'll pass to Helen in a moment, but it's huge. When I released the action plan, almost two years ago now, the first pillar was about prevention, because we know that about 25% of the money we spend on health care is actually completely preventable, and the areas where we've focused are smoking—and our smoking rates have gone from about 25% to under 20%, but we want to get below BC, which is at 14.5%. We've come about halfway to where British Columbia is today in terms of smoking. We're seeing success, but we've got a ways to go.

0920

The Healthy Kids Panel: We decided to focus on that because it is very, very clear that our kids today are not as healthy as they were a generation ago and that is a health care burden coming at us. That's why we launched the Healthy Kids Panel. It gave us a number of ambitious recommendations and that's what we asked them to do. How do we get kids more active, eating more healthy food so we actually see a reduction in childhood obesity? That's a big public health issue, and one we must tackle.

We're also very much wanting to improve immunizations, whether it's pharmacists offering flu vaccines in their pharmacies or whether it's increasing the number of vaccines that we offer at no cost to parents. In fact, the vaccines that we pay for now under our public program save a parent about $2,500 per child in vaccines they don't have to pay for any more because we're paying for them.

Of course, the whole Samir Sinha report was very much about preventing falls, keeping our seniors healthier and more active and out of the hospital.

There's a big focus on prevention. With some of those, it takes a bit longer to see the results, but for some of them we see the results quickly.

Maybe over to Helen.

Ms. Helen Angus: The only thing I would add to that is that in addition to the work on prevention—and I agree that it's a critical pillar of transformation and probably over the long term the best avenue to improve the health of the population. I would probably add in some of the work on integrated cancer screening—

Hon. Deborah Matthews: Yes, yes.

Ms. Helen Angus: —that is trying to better organize screening and improve screening rates. There's a project at Cancer Care Ontario, where I worked previously, that's looking at online risk assessments, and helping people identify what risks they may have for cancer and the screening they should undertake that would be appropriate for them.

Ms. Helena Jaczek: How is this actually filtering down to the health units? Are you modifying the standard programs, the guidelines? How are we ensuring—I sort of hear what's happening centrally. How is this rolling out right into the field?

Mr. Saäd Rafi: I think immunization was mentioned, so they are obviously a key participant there in all manner of immunization, be that for children or adults. I would say on inspections, with respect to the sale of tobacco products, smoking cessation tools are available to health units for their communities. In addition to that, tanning bed legislation—they have an inspection and oversight role there. The Chief Medical Officer of Health, Dr. King, has put out a strategic plan for this sector to work toward wellness targets and goals.

The other piece, I would say, is that a strong element would be some of the social marketing that's taking place, albeit at the ministry level. These are difficult needles to move in terms of behaviour change. My own knowledge and experience would be 25 years of change and continually marketing to get seat belt use from the low 70% to the high 90s. There's a direct correlation of safety and longevity associated with that, but that's a 25-year effort. Public health units are involved in many aspects in that regard.

Ms. Helena Jaczek: I guess, just picking up on the smoking rate in BC, which, as you said, Minister, is around 14% or so—that's a remarkable—actually, a very low rate, I would think, probably the lowest in Canada. Are we looking at what they did in BC and adopting practices potentially there that they introduced to achieve that, or is there a range of options that are being considered so that we can get down to that kind of rate?

Mr. Saäd Rafi: Yes, both. "Yes," I think, is the answer. Again, if I could just pick social marketing as an example: Some jurisdictions—it's been very effective if you look at cigarette tobacco products. What the federal government has done with respect to—you know, that's a very shocking set of photos that you see on products. So that's one approach.

The second is, then, a target market approach, so early onset of smoking behaviours. We know that 66% of social smokers end up being long-time habitual smokers, so that's one approach.

I think what we've learned from BC as well is to look at where they target which markets—but it's a different market in terms of it's a different population base; it's a different approach. As we said earlier to the question on other jurisdictions, you sort of take the best of other jurisdictions and see if you can make a made-in-Ontario solution that fits this market.

Hon. Deborah Matthews: What the anti-tobacco folks talk about a lot is de-normalization. Actually, my little five-year-old grandson saw a no-smoking sign. He said, "What's that?" He had never seen a cigarette. He had no idea what I was talking about. I thought, "He's age five, and he hasn't seen people smoking?" That's a good sign that maybe we're doing a good job on de-normalization. The fewer children who see adults or teenagers smoking, the better.

Ms. Helena Jaczek: Okay. Now, Ms. Angus, you mentioned health links, again one of those terms where it is a little bit difficult to understand the breadth of it and that this is a program and what it entails. Could you just talk a little bit more about the community health links? Who is the target of the programming and how are these health links being set up?

Hon. Deborah Matthews: I'm going to start—

Ms. Helen Angus: Yes, please do.

Hon. Deborah Matthews: —and then I'm going to hand it over to Helen, because she won't say what I'm going to say, and that is that in my opinion, this is the most exciting thing that's happening in health care in this province. Indeed, there's international attention being paid to community health links.

The premise of why do we need community health links: We need community health links because a very small number of people depend very heavily on our health care system. So 5% of people consume two thirds of our health care dollars. They are not currently receiving care in a coordinated way. They may have multiple specialists, multiple services, be receiving care in different places, getting their drugs from different pharmacies, and nobody is able to get all of the information to design an appropriate plan of care, with that patient and their family at the centre of that plan of care. So they're bringing in people from all parts of health care and beyond in a given community to really develop plans of care so that people get the right care in the right place at the right time.

One of the places they're starting is, looking at people who are very high users of the emergency department. These are people who need care; that's why they come into the emergency department. But if they keep coming back, it's pretty clear that they're not getting the care they need, so we need to do better by those folks.

This is something that the people who are engaged in community health links are very excited about, because it's empowering them to solve problems locally. Instead of pointing fingers at one another and being frustrated at their lack of control over the health care of an individual, they're actually solving those problems.

I'll pass it over to Helen.

Ms. Helen Angus: Just to give you some examples of the kinds of patients we're talking about, I think the minister may have mentioned earlier that 75% of the complex patients see six or more physicians; of those, 25% see 16 or more. It really argues very strongly for the need for a care plan that everybody can see—and you can imagine, with 16 different physicians, what the issues might be in medication management, in the number of visits, in the utility of those visits and the potential duplication or gaps, or the issues in the quality of care.

I think what's exciting about health links is the fact that it does bring all these providers together around patients, and being so person-centred in what they do, it really hasn't taken them very long to include housing providers and others to actually develop a single plan of care and a single contact person for these patients who are accessing the health care system a lot. I think this pattern of care, for many of them, is really about not getting what they need rather than what they do need.

0930

We've worked with the sector very closely to basically reinforce some of the natural referral patterns and relationships in the sector. So they identify the population, how they want to work together, who needs to be included, and we've stipulated some basic requirements around the engagement of primary care in a health link, a minimum population, an ability to track patients over time and look at the results. But we're also looking at providing them, I think, with a lower-rules environment in which they can innovate and provide some more creative plans of care for patients that truly meet their needs.

At the moment, we have 37 health links in the province, and the plan is to roll this out across the province as communities are ready to do this kind of work and can commit to it. We're starting to see some promising results. It's been less than a year, and I would say of our 19 early adopters, we have care plans being developed in all of those locations for complex patients and some pretty good emerging stories.

Ms. Helena Jaczek: How long do I have left, Mr. Chair, in this round?

The Chair (Mr. Michael Prue): You have about two minutes.

Ms. Helena Jaczek: Okay. I just want to pursue that a little bit more in terms of how this actually works. The minister referenced someone who's showing up in emerg several times. Who takes the initiative to say to that patient—is it someone within the emergency department of a hospital who says, "We've noticed Mrs. Smith has come here three times in the last two weeks"? If it is someone in the hospital, then do they get in touch with a family doctor? How do you evolve a health link program?

Ms. Helen Angus: Do you want me to answer that?

Hon. Deborah Matthews: Go ahead, yes.

Ms. Helen Angus: Sure. My sense is that it's actually quite different in different parts of the province. Some absolutely have taken that approach and have started in the emergency department. But it's actually a group of providers who have already agreed to work together, so it's not a cold call to a different provider; they've already decided how they're going to work to coordinate care for this group of patients, where they want to start and how they're going to come together to develop care plans.

Ms. Helena Jaczek: So is it mostly the family health teams that are taking the initiative?

Ms. Helen Angus: Well, I guess the family health teams, the hospitals and the CCACs are all required to be involved for us to say that that is a true, functioning health link. I think that where they identify patients might be in the family health team in some cases and in the emergency department. So they have come together and looked at the kinds of patients that they think need care coordination, and then they go and find those patients, wherever they are. That might be in the emergency department; it might be in a family practice environment; it might be in an in-patient bed and somebody awaiting discharge.

So they've taken a variety of approaches, and we're going to learn from that, but they are actively coming together as teams around individual patients and developing a care plan, and we've put a lot of effort into

identifying what the elements of a good care plan might be in order to make sure that it's comprehensive. There's a lot of work around what matters to "me," for patients, in terms of making sure the care plan actually addresses the things that are important to the patient, rather than necessarily the things that the providers think are the most important.

Ms. Helena Jaczek: Thank you.

Hon. Deborah Matthews: What we—

The Chair (Mr. Michael Prue): I'm going to have to stop you right there. We go on; the next 20 minutes is for the Conservatives.

Mr. Rob Leone: Thank you, Mr. Chair, and happy birthday, Minister—

Hon. Deborah Matthews: Thank you.

Mr. Rob Leone: —and to the parliamentary assistant. I didn't realize you shared the same birthday.

Hon. Deborah Matthews: Guy Fawkes Day. You know the guy who wanted to blow up the Parliament buildings? Just saying.

Mr. Rob Leone: Minister, I know my questioning ended off last week talking about the Healthy Kids Panel. I have a few more follow-up questions related to that, and then I'm going to hand it over to my colleagues.

Minister, I produced a letter last week that was sent by your ministry about the consultation process on the Healthy Kids Panel. The first consultation was planned for October 22, 2013, so a couple weeks ago, at least. The sessions were focused around following a number of things, one of which was the insights on a monitoring and evaluation system.

My first question to you: Did anyone come forward during that consultation to estimate how much it would cost to evaluate and monitor a system—I called them "junk food cops" last session, who will essentially go into convenience stores, grocery stores, places where unhealthy foods are being sold. How much is it going to cost to monitor that kind of system? Did anyone come forward with some estimates of cost?

Hon. Deborah Matthews: I have not been briefed yet on the results of the consultation. But I can tell you, if we were doing what is the cost of doing something versus what is the cost of not doing something, I think, on balance, there is no question that the cost of not doing anything would far outweigh the cost of doing something.

I look forward to hearing the results of the consultation. As I say, I have not yet been briefed on what was heard at those consultations.

Mr. Rob Leone: There were stories in the press earlier this month that talked about how principals in schools are sending junk food home. If they find junk food in a student's lunch, they are asking those kids who are bringing the junk food to school to bring it back home. That, I think, is part of an overall approach where third parties are monitoring the food that kids are eating, essentially, which, I guess, points to two interesting things. We're talking about, with the Healthy Kids Panel, the effect of marketing unhealthy foods to kids, yet in our schools, we have parents packing lunches with unhealthy foods. The question arises: Even if you ban the marketing of unhealthy foods to kids, what's to prevent parents from giving these kids unhealthy food in the first place, when we have that scenario happening in our schools today?

Hon. Deborah Matthews: I'm not familiar with kids being sent home with unhealthy snacks. I know that we have restrictions around what foods can be sold in schools. I'm not aware that anybody is reviewing what is in the lunch box—

Mr. Rob Leone: Yes, I think there was a CTV story that happened; I don't know if I have the exact date or the article in front of me here, but it happened around—I think it was during our break week, so just after Thanksgiving.

Hon. Deborah Matthews: Okay. I can't comment on that because I don't know what that story is.

Mr. Rob Leone: Okay.

Hon. Deborah Matthews: But what I can tell you is that marketing is very powerful. I think, as adults, we are seduced by marketing. Little children, who don't have the judgment yet developed to be able to sort out what is actually being marketed at them—I think it's worth looking at. We know that 80% of the marketing aimed at children is for unhealthy foods. That troubles me.

I hear that you're opposed to making any changes on that front, and I will add that to my consultation.

Mr. Rob Leone: Well, here's what I'm opposed to, Minister: the fact that we're legislating something here in this area. When you're saying, "We're going to ban this," you're not teaching people what is right and what is wrong. You're just saying, "You can't have this." This is just like the apple in the garden of Eden, so to speak. I think what's more powerful is if you say, "Parents, you're responsible for feeding your children. You can say no, and you should tell your children why you should say no." I think that's the parents' responsibility.

What I have an issue with is when the government oversteps that responsibility and says, "We're going to tell you what you can and can't do." I think, at the end of the day, that's not teaching anybody anything. That's just saying, "We have laws, we have regulations, and we're going to monitor what you can and can't do." I mean, taken to an extreme, that poses a very difficult challenge for government. But I think we obviously have to respect parental rights as well. That's where I have an issue—and what we were talking about agreeing and disagreeing with.

What you made mention of last week was that you were worried about the parent who had a kid who requested candy and the parent said no; they had a temper tantrum, and they were ushered outside the grocery store. I think that's par for the course as a parent. You're going to expect kids to have temper tantrums because a parent says no, and the reasons for saying no are obviously within what the parent respects. But what we're saying now—that we're afraid of temper tantrums; therefore, we should just ban these things to begin with—I think is just the wrong approach.

Hon. Deborah Matthews: I need to correct you, because I think you're going somewhere where we have no intention of going, and that is on banning the sale of junk food to kids. Nobody is talking about banning the sale of junk food to kids.

The Healthy Kids Panel report—and I know you have a copy, and I'm assuming you've had a chance to read it, because you obviously have a lot of interest in this topic—is very much about responding to what they heard from parents about what kind of environment parents want to raise their kids in.

0940

Parents raised issues. It's about helping parents make the healthy choice for their kids. That's the whole tone of that Healthy Kids Panel report. It's not about banning; it's about—

Mr. Rob Leone: It's banning advertising, though. That's part of it.

Hon. Deborah Matthews: That is something we're looking at. They did make the recommendation that we look at—

Mr. Rob Leone: Two recommendations.

Hon. Deborah Matthews: —that we look at the marketing of unhealthy foods to children, so that's what we're doing. We're consulting on that now. We've invited a range of people with a range of perspectives to participate in those consultations. I'm going to put you down as opposed.

Mr. Rob Leone: To Mr. Harris.

Mr. Michael Harris: Thank you. Good morning, Minister. Happy birthday as well, and to your parliamentary assistant, happy birthday.

My line of questioning will revolve around eHealth. I remember our discussion last year on eHealth in committee. I'd like you to tell the committee how many Ontarians to date do not have an electronic health record.

Hon. Deborah Matthews: We have about seven million Ontarians now with EMRs. We've got about 70% of family doctors using EMRs and about 60% of physicians overall. We are on track to have an EMR for every Ontarian by 2015.

I really want to give a shout-out to OntarioMD. That's the part of the OMA that's responsible for bringing doctors into the world of eHealth.

Mr. Michael Harris: Last year, when we asked you that same question, I think you'd mentioned around the same number. I'm just wondering why there's really no progress from year to year on that number.

Hon. Deborah Matthews: We are seeing progress, but why don't I make sure I have the most up-to-date numbers.

Mr. Michael Harris: Yes. If there's a progress report—or have you done a progress report or asked eHealth to provide you with a report on the update of electronic health records in Ontario? Could you make that available to the committee?

Hon. Deborah Matthews: Yes, sure.

Mr. Michael Harris: Great.

I noticed—everyone noticed—that Greg Reed recently left from eHealth. Why did Greg leave?

Hon. Deborah Matthews: Can I just—I've been corrected: nine million Ontarians. If last year was seven million and this year is this nine million, that is two million more Ontarians with an EMR.

Mr. Michael Harris: Greg Reed left as CEO of eHealth. Why did he leave?

Hon. Deborah Matthews: He had completed a very ambitious go-forward at eHealth. We were seeing significant progress. He made a decision to move on.

I want to take this opportunity to say that he put eHealth back on track, and I'm grateful for the work he did.

Mr. Michael Harris: Now, he did leave six months before his contract expired. Were you concerned about that?

Hon. Deborah Matthews: No. That decision was fine with me.

Mr. Michael Harris: I did see as well that he received a severance package of around $400,000. Is this standard? Is this normal? Do you think Ontarians would have a problem with Greg leaving six months before his contract expired and then being given a golden handshake of almost half a million dollars?

Hon. Deborah Matthews: That was the contract. That was in his contract.

Mr. Michael Harris: Where are you at, to date, with regard to hiring his replacement?

Hon. Deborah Matthews: That work is under way. Perhaps the deputy could speak about the strategic review that's under way and where that leaves us.

Mr. Saäd Rafi: Yes. The board has established a search committee. That search committee has gone through a process of interviewing candidates, and it's my understanding that they are coming close to concluding that process with a short list. They'll come forward to make a recommendation in due course to the minister.

In addition to that, we're looking at a strategic assessment of the functions of eHealth to determine what should continue on in what pace. That review will conclude, hopefully, in about a month.

Mr. Michael Harris: Minister, will that severance package, similar to what Greg Reed received, be, on a go-forward basis, in the new contract for the new CEO?

Hon. Deborah Matthews: That is to be determined.

I do want to say, though, that when I talk about nine million Ontarians with an EMR, that is significant progress, but what is even more meaningful to people who work, for example, in the community health links, is that we are sharing information amongst providers. Connecting the GTA are the five GTA LHINs, working so that all of the hospitals have access to the records of all of the people who have been there—and community providers.

In southwestern Ontario, we've got cSWO, connecting South West Ontario, where hospitals within southwestern Ontario, including in your riding, are connected, so people could go to a different hospital within that area

and their records would be right there, available for them. In addition, in the north and east, there is another effort under way to connect those providers.

This is the future of health care. It's a huge enabler for us to be able to continue to improve health care and keep costs under control.

Mr. Michael Harris: When you talk about cost control, a $400,000 severance package seems fairly excessive, especially when the salary for the CEO was over $300,000. I guess you would have approved that $400,000 severance package?

Hon. Deborah Matthews: That was in his contract.

Interjection.

Mr. Michael Harris: And he left early, of course. Rob, did you have something to mention on that?

Mr. Rob Leone: I just wanted to follow up on that, Minister. Why did he leave? Did he leave on his account?

Hon. Deborah Matthews: I would say that it was a mutual—

Mr. Rob Leone: Or did he get fired? Did he get fired?

Hon. Deborah Matthews: No, he did not get fired.

Mr. Rob Leone: Okay. So why, if someone leaves their contract six months early, do they get a $400,000 severance package? That's what I'm struggling with.

Hon. Deborah Matthews: That was the way his contract was written. He did not—

Mr. Rob Leone: So his contract was written that, "if you leave six months early, you're going to get a $400,000 package"? Why wouldn't he leave six months early?

Mr. Saäd Rafi: I don't know the details of his contract. I think the contract would have had provisions—

Interjection.

Mr. Saäd Rafi: The contract would have had provisions in it such that at the end of the contract, there would have been a severance payment. If they came to a mutual agreement, departing six months before, I don't know how that factors into the severance.

Mr. Rob Leone: Is it possible to table the contract at the committee?

Mr. Saäd Rafi: I don't know. I don't have the details of his contract as to what provisions might prevent that, but we'd certainly look into that.

Mr. Rob Leone: Okay.

Mr. Michael Harris: What would you say the estimate is to date with regard to how much it has cost Ontario for providing electronic health records, off the top? I mean, I'm sure you get briefings on eHealth.

Hon. Deborah Matthews: Sure—

Mr. Michael Harris: Do you have an idea of where we're at to date?

Hon. Deborah Matthews: So you're asking cumulative expenditures, including under Smart Systems for Health, before we took office?

Mr. Michael Harris: Let's say, while you've been health minister, what has been spent—or at least the government, your government?

Mr. Saäd Rafi: Yes, I would have to compile that over the last four years. I don't have the total at my fingertips, but we can get the compiled spending.

Hon. Deborah Matthews: But I think it's very important that you understand that when we talk about eHealth, we're talking about much more than simply electronic medical records in individual doctors' offices. We're talking about, for example, getting lab results immediately uploaded to the records in the doctor's office. We're getting much faster turnaround on diagnostic imaging, for example, that's facilitated. We've got a range of other services that are provided.

One of the most extraordinary ones, for me, is called ENITS, emergency neuro-trauma—whatever the acronym is. But what it means is that if someone has a head injury in a hospital that does not have a neurosurgeon on call, they can, in real time, consult 24/7 with a neurosurgeon who can view the image in real time, talk to the emergency room physician, and make a determination about whether or not that patient should be transported or not.

Mr. Michael Harris: Great. Thanks—

Hon. Deborah Matthews: We have saved millions and millions and millions of dollars of unnecessary transportation because that's happening in real time, thanks to eHealth. It's pretty hard to put a number on that.

Mr. Michael Harris: What about the diabetes registry? Last time we were in committee, we talked about—you'd given us an update on that. You said that it was in the stages of being completed, and you were looking forward to that. Then all of a sudden, months later, it was cancelled.

Hon. Deborah Matthews: That's right.

Mr. Michael Harris: Why was that cancelled?

Hon. Deborah Matthews: The first thing I want to make sure is clear is that the way that contract was structured, we did not pay for any of the work that was done by a vendor on that project.

Mr. Michael Harris: So eHealth has paid CGI zero dollars on the diabetes registry?

Hon. Deborah Matthews: That is my understanding.

Mr. Saäd Rafi: Yes, that's right.

Hon. Deborah Matthews: They did not meet deadlines, and we chose to cancel the contract. The reason we chose to cancel the contract was, first of all, it was taking too long. But the way EMRs had evolved, physicians actually were getting the information they needed to properly care for their patients with diabetes without the addition of this particular registry. So physicians were saying that the technology has actually made that diabetes registry not something that they would use. So it's the right thing for the people of this province to cancel that contract.

0950

Mr. Michael Harris: Is there any civil litigation between eHealth, the government and CGI with respect to the diabetes registry?

Mr. Saäd Rafi: Yes, I believe there is. They've brought a case forward. I believe it's a dispute on the

position of government in the interpretation of the contract.

Mr. Michael Harris: Would you be able to provide that contract to the committee?

Mr. Saäd Rafi: I don't know if it's possible to do that. Again, I have to seek counsel, considering if it's part of litigation—that's why I said—

Mr. Michael Harris: So, clearly, there's a disagreement between eHealth, the government and CGI with respect to the contract in terms of the not paying anything for services somewhat rendered. It's hard to believe any company would do any type of work for nothing, I suppose. I'm not sure if I believe the fact that the government or eHealth won't be paying anything for the diabetes registry. I'm curious to find that out.

Mr. Saäd Rafi: The way it was structured was under an alternative finance and procurement model. So if certain milestones weren't hit, then payment was not provided. That's how—and they're disputing that. That's what's causing this—

Mr. Michael Harris: So, Minister, Ray Hession, the chair of the board, is now interim CEO, correct?

Hon. Deborah Matthews: That's correct.

Mr. Michael Harris: I think his daily rate was $600 plus expenses. Is that continuing on while he's interim CEO?

Mr. Saäd Rafi: For the time that he spends in the interim role, yes.

Mr. Michael Harris: How long do you expect that role to remain interim?

Mr. Saäd Rafi: I think, as I mentioned, the search for a CEO has advanced. I can't say if it'll be two or three months but, I would imagine, in that ballpark.

Mr. Michael Harris: Potentially by the new year?

Mr. Saäd Rafi: Pardon me?

Mr. Michael Harris: Potentially by the new year?

Mr. Saäd Rafi: It depends on decisions that are made with respect to the CEO and the assessment of the review. I think it's—

Mr. Michael Harris: How has—

Mr. Saäd Rafi: —say how long.

Mr. Michael Harris: How has that process been going? Have you publicized or have you narrowed down the field of candidates? What are some of the qualifications that you've asked for?

Mr. Saäd Rafi: The board has put down a set of qualifications and objectives that have gone into a search process. My understanding is there's a committee of the board that is undertaking the search. They have interviewed a short list of candidates.

Mr. Michael Harris: Do you know if one of the qualifications will be for the CEO to have a PhD?

Mr. Saäd Rafi: I don't know that.

Mr. Michael Harris: I'm just wondering because I know we've paid for a lot of these PhDs to happen after the fact. Perhaps it would be wise to include a PhD in the qualifications so that Ontarians aren't on the hook for flying eHealth executives around Ontario, paying for PhDs like they did with Alice Keung, I believe. I'm not sure if we're—

Hon. Deborah Matthews: So you're recommending a PhD be required?

Mr. Michael Harris: Well, I'm just asking if that's in the qualifications.

Mr. Rob Leone: I'm not available.

Hon. Deborah Matthews: Neither am I.

Mr. Michael Harris: So you hope to have somebody in place at the beginning of the new year or roughly around there, Minister?

Hon. Deborah Matthews: The process is in place, and I would much rather take the time to find the right person than speed up the process.

The Chair (Mr. Michael Prue): And with that, I'm going to stop you. The next 20 minutes go to Ms. Gélinas.

M^me^ France Gélinas: Thank you. I will continue—

Hon. Deborah Matthews: Oh, dear.

M^me^ France Gélinas: —if my voice allows me, with hospital questions. Sorry. I'll try another Fisherman's Friend and see what happens. I thought I had good drugs, but they were not as good as I thought.

I'm talking about specific hospitals at this point. My first series of questions was general. This one will be within the Niagara Health System first. We're talking about the Queenston Street site and the Ontario Street site—

Hon. Deborah Matthews: I'm sorry; can you just lean into that microphone a little bit more? I'm having trouble hearing.

M^me^ France Gélinas: Yes, I can. Okay, so the Queenston Street site, the Ontario Street site, the Welland site and the Greater Niagara General site: How do I go about finding—maybe you can help me—what was budgeted for those sites and what was spent in those sites? I'd like to go back to fiscal 2011-12 and fiscal 2012-13.

Mr. Saäd Rafi: I think we'd have to talk to the hospital management as to how they allocate budgets to the various sites of the Niagara Health System. We wouldn't have an immediate understanding of that because there is a board that's responsible and then, of course, given the supervisor who is in place—the supervisor's role would overlap some of those dates. So we'd have to get that for you.

M^me^ France Gélinas: Well, precisely because we have a supervisor in place, doesn't the supervisor share information with the ministry, given that you appointed the supervisor?

Hon. Deborah Matthews: Absolutely, but I think you're asking for information by site, and I'm not sure we have that information, whether we have it by program or by site. We'll look into how deeply we can dive to get that information for you.

M^me^ France Gélinas: Okay, I appreciate it. I would like, while you do your deep-sea fishing, the information on the total number of hours of booked—scheduled and non-scheduled—OR time. It's really hard to find the

information about, basically, usage of OR time at the different sites. While the supervisor is there, I understand that this information has been gathered and looked at; it's just to share that with us. That would be the number of booked—scheduled and non-scheduled—OR times in those different sites. Right now, I think the information that is available is available by fiscal year 2011-12 and 2012-13. If you have it in another format, I would take that too.

Hon. Deborah Matthews: We'll see what we can do.

M^me^ France Gélinas: My last question specific to hospitals in that area is the proposed budget for oncology and cardiac programs at the new St. Catharines hospital, because it is one of those new—remember, I was talking to you before about the budget that we think is coming to a hospital, and then there's a new hospital, and there are other decisions that are made regarding their funding. So I'm interested in the decisions that are made regarding the oncology and the cardiac programs at the new St. Catharines hospital.

Hon. Deborah Matthews: When we were talking about different streams of funding into hospitals, we didn't talk about Cancer Care Ontario. They fund cancer procedures and, of course, there was no cancer program in Niagara until the new hospital at St. Catharines. That would have been funding that came from Cancer Care Ontario. So we'll undertake to—

Mr. Saäd Rafi: And it would ramp up over time.

Hon. Deborah Matthews: —see what we can do there.

M^me^ France Gélinas: Okay. I very much appreciate it.

I'm done with hospitals and I'm now moving onto long-term care. I'll start with some one-offs and then dive deeper into it.

The one-off: Every year I ask about the follow-up on the recommendations from the Casa Verde inquest. Do we have a scheduled update as to the recommendations that were done after the inquest was completed?

Mr. Saäd Rafi: I don't know that we have a percentage of response to the 85 recommendations of the Casa Verde inquest from 2005, but the major response was the introduction, as you well know, of the Long-Term Care Homes Act, and the multitude of changes that that act and its requirements for resident care had to respond to Casa Verde. Some of those elements would be, of course, special units for long-stay beds and some assistance with dementia and responsive behaviours. So Behavioural Supports Ontario is a response to that.

There has been a large and significant response to many of those initiatives, and as recently as this fiscal year, we continue to respond to some of the requirements and recommendations; for example, $10 million in funding to support the training of staff to deal with patients with behavioural and complex care needs; and again, changes in August to regulations that would see an improvement of the discharge process for people in specialized units. I could go on—the use of RAI-MDS I think you're very familiar with and how that has been taken across the entire sector for a better assessment, either pre-admittance or during any back and forth to hospital, for example, for long-term-care residents.

1000

M^me^ France Gélinas: Okay. So if I'm looking specifically at the recommendations on Casa Verde, I'm not going to have a report as to, "We had so many of the recommendations implemented. We're now ticking off another three for this year" or anything like that?

Mr. Saäd Rafi: I don't believe that exists, but I would like the opportunity to check if there has been a charter or something that would say, "Okay, 85 recommendations, 90% implemented." But I'm just not familiar with it.

M^me^ France Gélinas: Is there a policy as to what kind of follow-up happens whenever there is a patient-on-patient incident that leads to a patient's death? There is a lot of social media information circulating saying that 67 patient-on-patient incidents in our long-term-care homes resulted in the death of long-term-care residents in the last six years. Do you know if those numbers are exact? And if they're not, what are they?

Mr. Saäd Rafi: Well, first, there's a very regimented process for inspection and compliance incidents. So again, in the changes to the Long-Term Care Homes Act of, I think, 2010, there was a multitude of responses by long-term-care homes to critical incidents because they were alive and alert to the fact that they had to submit for all incidents. What that causes is a complete and utter increase in the number of incidents, because I think there's a caution applied.

Now, the causality associated from an incident that leads to a death—I mean, I don't know those numbers. I'm not familiar with a report that says X, because causality is difficult in very frail seniors. If we're talking about a particular attack or an incident between two residents, that too is investigated. Sometimes regrettable circumstances arise, tragic circumstances. There may be police called in.

I can't verify whether there have been 67 in six years because I don't know the causality of an incident—i.e., a fall is an incident. Who's at fault? Was it just an innocent circumstance or right through to very horrific circumstances?

M^me^ France Gélinas: Is there any way to review resident-on-resident violence that results in death? This is pretty serious. I don't think that the numbers are that huge, and if it is not 67, then I think the ministry has a role to put out what that number is, because it creates a lot of anxiety in families that are looking at, "Is this the right path for my loved one to go on?"

Mr. Saäd Rafi: Yes. I can't disagree with that, but I think what the ministry does in support of that point is, all compliance reports are posted on the website. The inspection of the homes is a very thorough process. The government is adding 100 inspectors to do the residence quality inspections. It's probably the most transparent process in long-term care that exists today. So I think family members can make a very informed decision about the homes in their community as to their compliance against very rigorous standards that came out as a

result of the changes in the legislation and the following regulations.

Would it help to be augmented by the number of incidences or deaths on resident-to-resident interaction? Perhaps, but I think, more substantively, the understanding of what the sort of compliance record of that home is, and then, obviously, a visit, an interview process etc.

M^me^ France Gélinas: I don't disagree with what you've said. Some of the information that is available to clients is dated. The up-to-date reports are not always there. Some of the information on particular homes is pretty old, so not that helpful. But I don't disagree that this is a good source of information and all that, but it's not always as useful, depending on the home that you are looking at—which brings me to—

Mr. Saäd Rafi: They may have a good compliance record; there may not be many incidents.

M^me^ France Gélinas: Well, then, it should still say.

Mr. Saäd Rafi: Fair enough.

M^me^ France Gélinas: The wait-lists for long-term care by CCACs: This too—it's very hard to do this on a website, so I will ask of you if you could give me—and pick a recent date, in October or September this year—the wait-lists for long-term-care homes by CCACs. I would appreciate it if you could table that with the committee—

Mr. Saäd Rafi: Okay.

M^me^ France Gélinas: —as well as the breakdown of the number of beds that are—I don't know if it was just me, but you used to have those little charts that would show municipal homes for the aged, charitable homes, not-for-profit, for-profit, and we could see the number of beds in each of those categories. That little chart is no longer there, and I was wondering where we were at with that.

I'm mainly interested in the for-profit versus not-for-profit, how many beds with—

Mr. Saäd Rafi: A breakdown of the number of beds by type of long-term-care facility, so municipal, not-for-profit, for-profit?

Hon. Deborah Matthews: Charitable.

M^me^ France Gélinas: And charitable.

Mr. Saäd Rafi: Yes, charitable. Okay.

M^me^ France Gélinas: There was a lot of talk about a staffing committee in long-term-care facilities, and I was wondering if I could get a status of the staffing committee for long-term care.

Hon. Deborah Matthews: The staffing committee for long-term care?

M^me^ France Gélinas: Yes, in long-term-care facilities.

Hon. Deborah Matthews: I'm not sure—

Mr. Saäd Rafi: As soon as I find out what that is, I'm certain we can provide you with a status report. I'm not familiar with a province-wide staffing committee, unless, perhaps, it's with the homes themselves, but I'll certainly look into that.

M^me^ France Gélinas: Sounds good.

In 2003, the CMI data was released, but not publicly. I was wondering if the information, either the RUG III—whatever—that shows the acuity of residents in long-term care, either provincially or by sector—can I have access to that data, and do you have any intention of making that data available publicly?

Mr. Saäd Rafi: I think we can get that information. I don't know its status in terms of public or non-public. I'm just ignorant on that. Sorry.

M^me^ France Gélinas: Okay. If it is not public, would you consider making public what shows the trend or the status of acuity within different long-term-care homes?

Hon. Deborah Matthews: We know for sure that acuity is increasing. People are needing more supports in long-term care than they did before, and the more successful we are at providing supports in the community—we know people in long-term care will need more help.

M^me^ France Gélinas: I think everybody agrees with that line of thought. Where the discourse comes is that some homes for some reason are way more affected than others. In some homes, acuity seems to have stayed pretty stable, as opposed to others, where acuity levels have gone really high. Because this information is not available publicly, it brings a lot of hearsay as to, that homes keep refusing high-acuity clients referred to them as opposed to that one, which takes them all. Do you see where I'm going?

Hon. Deborah Matthews: I do see where you're going.

Mr. Saäd Rafi: Yes.

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

Another piece of information that I used to request through freedom of access of information—and then I got it regularly without paying five bucks, but it's not coming anymore, so I'm going to ask for it again—the number of full-time equivalents and paid hours by nursing, and personal care classifications—the same thing. It used to come by nursing home, homes for the aged, charitable homes and the for-profit, and you'd basically see the staffing—

Hon. Deborah Matthews: The staffing ratios?

M^me^ France Gélinas: —the staffing ratios. Is this something that you still compile? If you could share that with us.

Mr. Saäd Rafi: Yes.

M^me^ France Gélinas: Thank you.

Another question regarding funding has to do with, here again, the breakdown of funding to long-term-care homes in the per diem and how the 2% increase was allocated. So basically, what are the per diems for the different envelopes—personal care, nursing etc.—and where does the 2% increase apply? Can we actually see this, the 2% that was in the 2013 budget?

1010

Mr. Saäd Rafi: Yes, we can.

M^me^ France Gélinas: Okay.

Mr. Saäd Rafi: We can give the sort of typical per diem, because as you know—I don't need to tell you all this; you know all this—that varies based on acuity or

need. But, yes, we can show where we apply the increase by the per diem categories, of which there are four.

M^me^ France Gélinas: Okay. So do you know—is the 2% going equally to all four categories, or is the 2% targeted to a specific envelope?

Mr. Saäd Rafi: It's the latter. I want to be certain of my response with respect to where it's allocated, so I won't venture to just guess, if that's okay.

M^me^ France Gélinas: Okay, no problem. In the allocation, does the level of acuity come into play when you do the 2% increase? How are the decisions made? Is this a formula? How does it work?

Mr. Saäd Rafi: Well, the per diem is based on basically a CMI of 100, right—the base level CMI, as you know. So the 2% doesn't fluctuate, meaning the dial moves higher if the acuity is higher. The acuity is assessed. The 2% is applied as, I think, more of a function of the overall resident care needs in the 2013-14 budget for long-term care. And then acuity is looked at after that, I believe. Otherwise, it would be way too complex for the 77,000 residents.

M^me^ France Gélinas: Okay. I wouldn't mind if you would basically explain the calculation for the 2%—

Mr. Saäd Rafi: Sure.

M^me^ France Gélinas: —so that I could understand.

The Chair (Mr. Michael Prue): About one minute.

M^me^ France Gélinas: All right. Anything else you would like to share about long-term-care funding in 60 seconds or less?

Mr. Saäd Rafi: It's seen a significant increase over the last 10 years, and I think—

Hon. Deborah Matthews: From $2.1 billion to $3.8 billion. That's almost a doubling in 10 years.

Mr. Saäd Rafi: Some 6% average growth.

Hon. Deborah Matthews: So 80%.

M^me^ France Gélinas: I heard the discussion you had with the member from Oak Ridges–Markham about—do you see an expansion in the number of long-term-care beds, or do you really see a new direction for looking after—

Hon. Deborah Matthews: Absolutely, we see a new direction. There probably are parts of the province where there may need to be more capacity in long-term care, but we are very much focused on expanding community supports so that those people who go into long-term care really need to be in long-term care. Our most recent data that I've seen shows that about one third of people who go into long-term care actually could be cared for at home with the right supports.

The Chair (Mr. Michael Prue): We'll have to stop you at that point. It now goes to the government. Ms. Jaczek, we are going to continue until approximately when the bells start to ring, so you'll have to do the last half of your 20 minutes when we come back this afternoon.

Ms. Helena Jaczek: Sure.

The Chair (Mr. Michael Prue): Okay.

Ms. Helena Jaczek: Thank you, Chair. If we could return to health links, because it's a new program—and I'm still kind of trying to get my head around how a group of professionals decide to form a health link. I mean, it sounds like the initiative is coming from community health professionals themselves. So how did they initiate? Did they apply for some special funding? Are these patients rostered? Are they invited to join? Is funding dependent on the rostering? How are you ensuring there's some geographical representation, that this is being taken up? I mean, it sounds intuitively like a really good idea because you're going to be managing these very complex patients with a view to avoiding hospitalization etc. I think, conceptually, everyone can understand this is good, but again, I'm really interested in how it's being operationalized to the extent—also, how are you going to be measuring the success and so on? Could I just have a fuller picture?

Hon. Deborah Matthews: Let me start, and then I know Helen will be able to go into more detail.

It was exactly a year ago, in a speech I gave at HealthAchieve, that I talked about this idea of health links. We were very pleased that 19 community organizations had already been talking about how they would move forward on something like this. We call those our early adopters. Those 19 have received a small amount of funding.

We're not replacing providers. It's using the existing providers within that geographic area. They've applied. We've said, "You have to include primary care; you have to include a hospital; you have to include a community care access centre"—the home care—"and other providers."

They have come together voluntarily. We now have—37?

Ms. Helen Angus: Thirty-seven.

Hon. Deborah Matthews: —37 up and running, with more in the works. We estimate that to have the whole province covered, we'd need about 100.

These are groups of people who collectively are sitting around the table in their communities, saying, "We can provide better care for patients and better value for money if we work together, focusing on those folks."

We said to the health links—we wanted them to be getting results quickly, so we said, "Choose 100 people in your area who you think would benefit from a community health link." I actually was at a meeting where physicians were fighting to get their patients accepted into the community health link, because they really saw that a particular patient would benefit from that kind of much more holistic support.

As they go on—I mean, they had to start somewhere. They've identified people. The data from ICES has been very helpful as well in determining who would benefit from this kind of care.

It's voluntary; it's inclusive. There's a lead organization, but it's different across the province. Sometimes it's a family health team; sometimes it's a hospital; sometimes it's public health. I think we have public health taking the lead on one or more health links.

They are there in the community. As I say, they collectively work, focusing on one patient, their family and the needs they have.

Ms. Helen Angus: The minister is right: We started with early adopters that had already demonstrated a high degree of co-operation, where the family health team was highly connected to the hospital, the CCAC and others.

It's a two-step process to become a health link. First, there's sort of a readiness assessment: Do you have the preconditions to be able to develop coordinated care plans, identify the complex patients and work together? Within about two months, they then have to submit a business plan that goes into more detail about how they're going to operationalize their health link.

As a practical matter, they have to identify who would be the lead agency for pulling all this work together. We have six community health centres in the lead. We have 14 family health teams, one family health organization—so it does vary across the province in terms of who's the lead—and nine hospitals. We've got community care access centres in the lead and community service organizations.

Many of these patients have different kinds of complexity in their lives, so they're looking at including—we've seen mental health agencies, public health units, food banks, emergency medical service providers, education, community and social service providers, long-term-care facilities and, in some cases, the police, because of forensic mental health issues and conflicts with the law.

The partnerships are probably more than we had even expected at the beginning. We know that as of probably late October, there were 650 different organizations across the province engaged in organizing care for patients. When they convene a care plan, all the providers who are involved in the care of that individual come together to actually develop one plan. In some cases, that could be 10 different physicians sitting around the table with some community nursing, the CCAC and others, actually participating in the development of a unified care plan—which has been sort of the missing ingredient, I think, for those patients. They would say that they might have had a medical care plan from their leading specialist, but they wouldn't have had a comprehensive care plan that addresses their medical, functional and social needs. That's what this really brings together. It's a kind of graduated investment.

1020

I think you also asked about metrics, and I can go through some of those, if that would be helpful. Obviously, the first job that we've asked them to do is that all complex patients have a coordinated care plan. We do count. We will be counting the numbers of patients who are touched by this and who benefit from a plan. We've asked them to make sure that complex patients and seniors have regular and timely access to a primary-care provider, because, really, the role of primary care is so fundamental to the organization of care for these patients. We've put that in the sightline as an early metric that we want to see some movement on.

I think that, over time, we'll start to see some of the measures that are more about coordination, best practices and the hand-offs between providers. We're looking at, for these patients, reducing the time from primary-care referral to a specialist; reducing the number of 30-day readmissions to hospital, because some of those readmissions, as you know as a physician, are really about the quality of the hand-off and the discharge in the first place; the number of avoidable ED visits for patients who could be best managed elsewhere; the referral-to-home-care visit; and unnecessary admissions to hospital. It's metrics like those that, I think, we're going to see within a year or two, and then really looking at also making a measurable improvement in the patient experience of care and looking at some of the tougher ones around alternative level of care.

Ultimately, when you organize care better and provide high-quality care, we're looking at the overall value of the services provided. We think that we can actually reduce the average cost of delivering care to those patients without compromising quality, and are looking at developing more metrics around cost.

Ms. Helena Jaczek: Okay. I think, then, what I'm hearing is that there's no additional funding for these programs. Essentially, the billing is done in whatever way that particular group of professionals has always billed. Is that correct?

Ms. Helen Angus: There's a little core support for health links in terms of project management—to convene, basically, the case conferences and the development of the care plan. We know, for example, that in the cancer system that's a regular course of business around a multidisciplinary case conference. It requires a little bit of structure to make that happen, but it's actually a small injection of funds and the balance is really on having the providers work together, being compensated in their usual way for better organizing care around these patients.

Ms. Helena Jaczek: Does the patient know that they are part of health links?

Ms. Helen Angus: They do. We're starting, as they develop care plans, to see the benefits from the patient and hear their stories about how their care has been improved by the workaround that has been done in developing the care plan for them. There are different approaches in different parts of the province; we're going to learn from that. Some have a patient passport. They've been quite innovative in making sure the patient is both included in the development of the care plan but that they also know what their care plan is, that they are part of that. Their family members may also be part of it. They may have a physical document that helps them understand what their care plan is, but it's very patient-centred in terms of what their goals and objectives are, and I think that's one of the great features.

Ms. Helena Jaczek: So patient satisfaction is something that's going to be measured, I guess.

Ms. Helen Angus: Absolutely.

Hon. Deborah Matthews: And patients get a contact person who connects them to all of their providers. That

navigation function that we hear so much about is very much addressed. The question, "Does a patient know?": Absolutely, because nothing is happening in their plan of care without them fully understanding what's happening. It's really all about them, so they listen very carefully to what the issues are.

We've got one story of a frequent user of health care, and the issue, really, was bedbugs. I see Mr. Colle sitting there. It was bedbugs. Once that was dealt with, everything else went a lot more smoothly. Under the old system, I'm not sure where that person would have got that help. It would have been hugely frustrating.

Ms. Helena Jaczek: Mr. Chair, shall we—

The Chair (Mr. Michael Prue): Okay. I think this is an appropriate time, then, and you will have the balance of the time when we come back.

We now stand recessed until approximately 3:45 this afternoon, and we'll see everybody back. There is still birthday dessert for anybody who wants some.

We stand recessed.

The committee recessed from 1025 to 1548.

The Chair (Mr. Michael Prue): We will call the meeting back to order. The questioning is with the government. You have seven minutes remaining.

Ms. Helena Jaczek: Thank you, Chair. Minister, we were talking about the community health links program, and I'm sure as they recruit more and more individuals to those health links, a number of them will be seniors, given that seniors, as we know, often have complex issues and, as you've said, often are on many different medications, are sent to many specialists etc.

So you did announce a seniors' action plan, and much of that was based on Dr. Samir Sinha's report. There was a very large number of recommendations—I think something over 100 recommendations.

Hon. Deborah Matthews: One hundred and sixty-seven, I think.

Ms. Helena Jaczek: So could you just tell us how you and your staff have been going through those recommendations and some of the initiatives that you're following up on that come out of those recommendations?

Hon. Deborah Matthews: Absolutely. He travelled the province. He spoke to literally thousands of people. People could inform the strategy online. He was able to narrow it down to 167 recommendations. They were very much focused on wellness, prevention and coordination of care. He went beyond the traditional health sector supports and programs to include things like housing. You heard me talk about bedbugs earlier. Transportation is a big issue. When our seniors can't get to the appointments that they're told they should go to, they don't go. So his report was visionary. It was ground-breaking. It was all-encompassing, and we are moving forward on implementing.

One of the things he said is that every senior should have a primary care provider. That should go without saying. Just like we did with people with diabetes, we've said, "If you have diabetes and you don't have a primary care doctor and you want one, we're going to get you one." So now we're at 100% when it comes to people with diabetes.

We need to now turn our attention to seniors and make sure that they have that primary care provider who will coordinate their care. We very much see a strengthened role for primary care providers. Sometimes they tell me they feel on the periphery of the system as opposed to one person responsible for coordinating care.

Dr. Sinha talked a lot—and this is related also to the Home First philosophy. What we now know is that if seniors have an event—if they have a stroke or they have a fall and there's something that puts them in the hospital—decisions are made about their capability of returning home prematurely. It has been in the hospital when people are still recovering where the doctor is saying, "You can't go home anymore." Now what's happening is, they're saying, "You can go home. You're going to need intensive supports. See how you're doing and then we'll make a decision in a few weeks about whether or not you can stay home."

He saw a role for long-term-care homes. It's not well known that there are actually hundreds of vacancies in long-term-care homes, but they're not where people choose to go often, whether it's the geography or whatever the reason is. So he saw a way to use long-term-care homes as a way to take people out of the hospital, when they're not ready to go home but they don't have to stay in acute care, bring them into the long-term-care home, give them those activation supports they need and then they can often move back home. Sometimes they can't go back home, but often they can.

We added 250 short-stay beds, where people would come in for a number of weeks usually and then often carry on home. We had some of those. We've significantly expanded. I think the number is that 7,000 people last year who benefited from those short-stay beds. Again, it's all about doing that assessment and providing supports that get people stronger and to go home if they can. He very much talked about the continuum of care: supporting out-of-hospital care via hospices or supportive housing and so on.

He did talk about the increasing challenge around behaviour for people with dementia. We visited Bloomington. We know that people with dementia present real challenges to staff, and they need to be trained to deal with them well. We're seeing wonderful, wonderful stories that are coming out of Behavioural Supports Ontario. When staff and caregivers are trained, it's a different way of thinking about people, because people with advanced dementia don't respond the way other people do to various stimuli. If you can understand, sort of get inside their head, and provide the right supports for them—we've seen what I almost think of as miracles; people who were having really difficult times that had an impact on other residents and staff are now, because someone has taken the time to understand them, contributing members of the long-term-care community.

There were a range of recommendations, and we are implementing as we can. Maybe the deputy would care to add to that.

Mr. Saäd Rafi: Sure, certainly. I think there has been actually significant progress against the 167 recommendations, the bulk of those being health related, some being for seniors. The Seniors' Secretariat is moving on some of them with respect to senior-friendly communities, which more and more, from a planning point of view, we're seeing as a key interest in communities and municipalities around the province. House calls: I think we're seeing about 30,000 more of those taking place, which is a terrific response by the OMA's family physician section. The health link piece we talked about, and as you already mentioned, that's going to benefit a lot of seniors for certain. An additional 200,000 seniors are receiving improved physiotherapy services, who, as we heard throughout the discussions over the last few days, were not receiving effective treatment for true physiotherapy, falls prevention. I would say that there's the convalescent or short—

The Chair (Mr. Michael Prue): I'm going to have to stop you there. The 20 minutes is up, so hold on and ask the question again.

Mr. Saäd Rafi: Sorry. Thank you.

The Chair (Mr. Michael Prue): We are now into the last round of 20-minute rotation, starting with the Conservatives.

Mr. Steve Clark: Good afternoon, Minister.

Hon. Deborah Matthews: Good afternoon.

Mr. Steve Clark: Minister, on October 29, I think it was, I asked you a couple of questions—I actually didn't ask you a few questions. I made a statement, using the Chair's word, when I started talking about a couple of my constituents who had Ehlers–Danlos syndrome, or EDS.

Hon. Deborah Matthews: Yes.

Mr. Steve Clark: Over the weekend—in fact I'm looking at the date now, November 2—Hugh Adami in the Ottawa Citizen wrote about an Ottawa resident, Adam Gard, who also has EDS. I don't know Mr. Gard or his wife, Ruth, or his two boys. All I know of them is what I've read here in this Ottawa Citizen story. I'm going to get to the dollar figure that the ministry has released as what they've covered in terms of out-of-country coverage in a moment. But earlier in the story, there was a reference to our health system lacking EDS resources. I know you and I spoke about a year ago on a conference call about my two constituents Charlie Smith and Jessica Covey. There was a neurologist in this story, Minister, who indicated that Ontario's health system lacks EDS resources. Do you agree with that?

Hon. Deborah Matthews: Well, I could tell you that I have looked into this because there have been stories that have come forward where people are requesting out-of-country coverage. We have a very robust out-of-country program. I think 91% of applications to out-of-country are approved. So we're not stingy when it comes to out-of-country.

We do, though, have pretty clear criteria that if care cannot be provided in a timely way in Ontario, we then consider out-of-country, but if there is care available here, then we do not fund out-of-country. With this particular disease, it's almost how it's framed in the sense that we have doctors, I believe, at—I think I saw the list of 11 hospitals.

Mr. Steve Clark: Yes, and it does say, Minister, in the story—I'll quote the story: "But the health ministry says neurosurgery 'to stabilize joints in the neck' is available at 11 hospitals in the province, including The Ottawa Hospital." What I found strange, because I remember the conversation that we had back in November, where you said it was almost impossible—because I asked you. I said, "Can you give me a list of neurosurgeons that perform this surgery?" And you said, "The college doesn't do that," and you were unable to give me a list as the minister. And I find it strange that you can't get me a list of neurosurgeons, but you can give me a list of 11 hospitals that perform the surgery. I don't really get that. Is there a problem in you providing the complete list of the 11 hospitals that give EDS surgery?

1600

Hon. Deborah Matthews: I'll happily read it into the record right now.

Mr. Steve Clark: Good.

Hon. Deborah Matthews: Hamilton Health Sciences, Health Sciences North, Hospital for Sick Children, Hôtel-Dieu Grace, St. Joseph's in Toronto, London Health Sciences Centre, the university hospital in Ottawa, St. Michael's Hospital in Toronto, Sunnybrook here in Toronto, Thunder Bay Regional Health Sciences, Trillium Health Centre in Mississauga and UHN here in Toronto. That procedure is done—that particular stabilization of joints—in those hospitals.

I think the other thing is—because EDS is a complicated disease, so it's not just surgeons people need. They need rheumatologists, pediatricians, pain specialists, neurosurgeons, psychologists, physiotherapists and occupational therapists. Patients with EDS receive services for chronic pain, including physician specialists and interdisciplinary providers at various clinics in the province, including SickKids and Mount Sinai.

As I say, the out-of-country program is there for people when there is not expertise here. When there is expertise here, we do not fund people to go out of country. I just want to say that I understand, because if I were a parent with a child with EDS, I would do a lot of research online. That's of course what patients do, and we are finding that there are providers, in the States, in particular, who kind of package their expertise in a way that Ontario hospitals and physicians don't.

Mr. Steve Clark: Yes, and certainly, when I speak to people from the EDS community, they do mention Dr. Henderson from Baltimore as someone who has done 200 procedures.

I appreciate you indicating the hospitals that do the operation to stabilize joints in the neck. Again, I would like to hear, at some point, an answer on how many EDS surgeries were done to stabilize joints in the neck, because I understand that the procedure can be done for a variety of purposes, not just EDS.

Hon. Deborah Matthews: Exactly.

Mr. Steve Clark: So if you could provide me, at some point, the number of EDS versus non-EDS surgeries?

Hon. Deborah Matthews: I'm not sure—we'll see what we have, but I'm not sure we captured diagnosis. We do capture the procedure.

Mr. Steve Clark: Okay. In the story, it mentions that a Ministry of Health official has indicated that you paid almost $930,000 for out-of-country EDS surgeries in 2011-12. That was the figure your ministry has released. That would have been entirely approved under the old system, where it was a GP, not a specialist, that approved those surgeries. Is that correct?

Hon. Deborah Matthews: You know, you really have me at a disadvantage. I don't have the article, so it might be helpful to—

Mr. Steve Clark: There's nothing that you don't already know from the article, other than the fact that it says that $930,000 was approved.

Hon. Deborah Matthews: So if a ministry spokesperson said that—but things change, right? Every application is reviewed; as I said, over 90% get approved. So it's hard for me to know on a case-by-case basis—

Mr. Steve Clark: All I'm saying, Minister, is that you seem to have some documents there about EDS, and I would love to get a copy of them. You quoted from them, and I will provide you with the article from the Ottawa Citizen in reverse, but I would love to get the documents that you're quoting from, because I think it's very important. This was a surprise number in the Ottawa Citizen to the EDS community. They were unaware that $930,000 had been covered for out-of-country EDS surgeries. This was a surprise. I would love to see, in 2012-13, how many dollars have been spent out of country. My worry is, it's been zero because of the change in your policy.

Hon. Deborah Matthews: I just want to be really clear about the change in policy. The only change is that we require a referral from a specialist. It's unrealistic to expect family doctors to know what expertise is available here in the province. The specialists do have a better sense of what's available, so we now accept applications from specialists.

Mr. Steve Clark: But Minister, I want to put on the record—

The Chair (Mr. Michael Prue): I don't want to interfere, but we need to be clear here for the record. You are asking the minister for documents in her possession at this time today.

Mr. Steve Clark: She was quoting from them, yes.

The Chair (Mr. Michael Prue): All right.

Mr. Steve Clark: I would like them, yes.

The Chair (Mr. Michael Prue): Okay.

Mr. Steve Clark: And I will give her and give members of the committee—

The Chair (Mr. Michael Prue): I haven't heard yet that the minister can provide those.

Hon. Deborah Matthews: We'll do our best.

The Chair (Mr. Michael Prue): All right. Thank you.

Mr. Steve Clark: I just want to clarify again: This article—and you can confirm whether the numbers are correct or not. This article quotes a ministry official saying that $930,000 of out-of-country EDS surgeries occurred in 2011-12. That was the statement. My question to you is: Was all of that $930,000 approved prior to your change in out-of-country approvals?

Hon. Deborah Matthews: I will look into that. I think it's also important to point out that a child with EDS would require a number of procedures, not just one procedure.

Mr. Steve Clark: I am aware that in some cases that happens.

Hon. Deborah Matthews: Yes.

Mr. Steve Clark: The other issue I would like—those were the numbers for 2011-12. I would also like figures—because, again, I'm worried that it's zero dollars. I would like to know the amount paid in 2012-13 for out-of-country EDS surgeries as well.

Hon. Deborah Matthews: We will do our best, if we can get those numbers for you.

Mr. Steve Clark: I hope you can get the numbers because, obviously, your ministry was able to get the $930,000. Obviously they were able to get the 11 hospitals. It was pretty easy for you to read into the record. I'm just saying, again: There seems to be a big gap in the documents from before the policy change to after the policy change.

Hon. Deborah Matthews: I would suggest that there might be other factors. I don't know what the 2012-13 numbers are. It could be that a doctor has moved here or doctors here have built up their expertise. If there are a lot of factors other than requiring a specialist as opposed to a GP—

Mr. Steve Clark: Minister, I would love if that's the case. If there was a new doctor who could serve EDS patients, I would love to find out who that doctor is.

Hon. Deborah Matthews: Okay. We will undertake to get you this information—

Mr. Steve Clark: But my final comment, before I defer to Mr. Leone—and this is to back up my statement from the 29th; I'll make it again. This story underlines that this family has to raise $70,000. Again, it just, to me, speaks to your change in out-of-country coverage, that more and more families have to raise money because of changes that you've made in the health system.

Hon. Deborah Matthews: I can't let that comment go.

Mr. Steve Clark: I'm not asking for a comment; I just said that I'm making a statement.

Hon. Deborah Matthews: You've made an assertion, and I would argue that the change we made is actually streamlining the system because specialists have a much better sense of what other options are available for people here in Ontario and what's available outside the country.

Mr. Steve Clark: But Minister, people are raising funds because the system won't serve them, and that's a concern.

The Chair (Mr. Michael Prue): Mr. Leone.

Mr. Rob Leone: I'm just going to piggyback on the back of that, Minister. A question I had as that whole discussion was unfolding was: Does the ministry track how many services that are provided out of the province, whether it's another province or in the United States, that the government pays for versus how many surgeries and things take place that come out of the pocket of the individuals? Does the ministry track what's going on with particular patients when they—

Hon. Deborah Matthews: We definitely track what we cover, and we've had a concerted effort to reduce out-of-country by providing more services here. For example, we're opening an eating disorder clinic so that people don't have to go to the States for that treatment. We are really looking at out-of-country because it's more expensive and you don't get the continuity of care that you do if you have a provider here. We want to provide care here whenever possible. But there are some times when the expertise is so narrow, so specialized, that we don't have someone here who can do it comfortably within their scope of practice. We know who we fund, and, as I say, 91% of applications are funded. I don't know how we track the remaining 9%.

Mr. Rob Leone: It was out of curiosity. I didn't really know if you tracked both expenses paid by the government and paid by the individuals themselves.

Hon. Deborah Matthews: We would know only if they applied and were rejected.

Mr. Rob Leone: Okay.

Hon. Deborah Matthews: And we wouldn't maybe know whether they used an Ontario provider or not.

Mr. Rob Leone: It has always been one of those lingering questions, because you hear lots of stories of folks, like Mr. Clark had outlined, who are raising funds or paying out of pocket for particular services out of the province. I've always wondered what that number would be, that discrepancy.

Minister, I want to change tack just a little bit here and talk about LHINs.

1610

Hon. Deborah Matthews: LHINs, yes.

Mr. Rob Leone: Now, my first question may be a simple one and maybe not. I think in my mind it's simple, but I'm awaiting your answer. Can you give me a sense of what the role of the LHIN is versus what the role of the Ministry of Health is?

Hon. Deborah Matthews: Absolutely. The role of the LHIN is to manage the integration and coordination of the health system within the boundaries of the LHIN. I'll give you a good example. In my LHIN, the South West LHIN, we had wait times that were far too high in some hospitals, but very, very low and excess capacity in other hospitals. So what the LHIN did was it went to work, and it worked with primary care providers, working with them to refer patients to those hospitals with the shortest wait time, so London Health Sciences could do the more complicated cases and other hospitals could do the less complicated cases. So, instead of sending someone from Kincardine to London, they could go to Owen Sound.

We've seen a real success in evening out those wait times by managing the system. You couldn't do that if every hospital was managing their own volumes, so it's forcing hospitals and other providers to work together.

Mr. Rob Leone: So the Ministry of Health, in that whole scheme, does what exactly?

Hon. Deborah Matthews: We set targets, so when it comes to wait times, we've got provincial targets, and we allocate funding based on wait times, to bring down wait times when they're too high, and we hold the LHINs to account when it comes to getting those wait times down, not just within the LHIN but at hospitals within the LHIN.

That's just one small example of what LHINs do, but it's a coordinating function. They're doing great work getting home care, working with hospitals, so there's a much smoother transition from those different—I hate to use the word "silos," but I will—those different providers really working on strengthening the transitions of care.

Mr. Rob Leone: Right. So when an organization receives funding for providing a health care service—let's use maybe reduction of wait times or a community care scenario that I can't just think of off the top of my head—who makes the decision whether community organization A over community organization B gets the money? Is it the LHIN, or is it the Ministry of Health?

Hon. Deborah Matthews: We set the targets. We say, "Here's what we want you to achieve," so as we've increased funding to the community sector and held the line on other parts of the health care system, we've been very clear with the LHINs. We want to reduce ALC rates—alternate level of care, people in hospital who could go, should go, elsewhere. We want to see reduced 30-day readmission rates. So we set the outcomes that we want, and then they, with their local knowledge, make decisions about where the money would go to achieve those outcomes.

Mr. Rob Leone: So those decisions on which organization is going to carry out a function, then, are made by the local health integration network of that area, whether it's South West or Waterloo Wellington?

Hon. Deborah Matthews: Yes.

Mr. Rob Leone: So the contract is essentially with the LHIN, not with the Ministry of Health. Is that true?

Mr. Saäd Rafi: Well, would have an accountability agreement. So, for example, with a community agency or a hospital, they would have an accountability agreement. If I could use a specific example, I would use the wait time money from first assessment to first visit by a nurse or a PSW. That was a specific strategy set to get the wait times down to five days, and so for nursing, for example, we knew which LHINs were at or about five days. So that was sort of, I would say, directed.

However, the remaining half, almost, of the funds that were allocated out of the government's budget, the LHINs have worked with CCACs to determine how best to disburse that money to deal with the increased volume of community services.

So it's not always linear in terms of, hand the money over, and they make the decision; mostly it is for the $24 billion that they have oversight on. They do that through accountability agreements, in some cases through MOUs, working with long-term-care homes, hospitals, community services and CCACs.

Mr. Rob Leone: One of the reasons why I'm asking this question is because I was a little confused, because every time I get a letter from your ministry, Minister, it's always about congratulating X organization for getting X number of dollars to perform a particular service. Now, that decision was not made by the ministry; it was made by the local health integration network. Is that the way it works?

Hon. Deborah Matthews: I'd have to see what letters you're referring to.

Mr. Rob Leone: I don't have any on me, but I know in my binder there are usually two or three in a given week that say—you know.

Hon. Deborah Matthews: It might be wait-time funding for the Cambridge Memorial Hospital.

Mr. Saäd Rafi: So $24 billion would be under the aegis of the LHINs' planning and accountability money. That still leaves approximately $25 billion in the areas of physicians; certain nurse expenditures; assistive devices; the drug program; provincial programs, which would be about cardiac, cancer, neurosurgery; community labs; and family health teams. So there's another, literally, little more than half of spending that the ministry is also dealing with, so it could be one of many different sources of funds out of the $49 billion that would go out.

Mr. Rob Leone: Okay, well, that actually provides a lot of clarity.

The Chair (Mr. Michael Prue): Last minute.

Mr. Rob Leone: Minister, I get a lot of these letters that state that some organizations are getting money or some group is getting money for services provided, but I never have any letters from you stating that money has been no longer continued, or we're not going to continue funding particular programs. So why do you give the letters on the one hand saying that organizations are going to get money, but I never see letters from you saying that funding has been discontinued for whatever reason? Money is discontinued, but I never get a letter from you. Why would that be?

Hon. Deborah Matthews: I would suggest you sit down with the LHIN if it's a LHIN program, because they have had to make decisions where some organizations either see a reduction in their funding or are flatlined in funding while others get more because they are shifting resources around. We're very focused on evidence, and if we can see demonstrated results from organizations in an area where we need to do more, we'll do that.

The Chair (Mr. Michael Prue): I'm going to have to stop you there. I don't think I was clear the last time. This is the last 20-minute round, but there is a 10-minute round for each party after that. So your last 20-minute round, Ms. Gélinas.

M^me^ France Gélinas: All right.

Hon. Deborah Matthews: You can make it?

M^me^ France Gélinas: I have no idea. It can only improve. Sorry. Yes, it hurts.

Hon. Deborah Matthews: Do you want to just write out your questions?

M^me^ France Gélinas: The healthy home renovation tax credit—it's coming back. Healthy home renovation tax credit: How many people? How much money?

Mr. Saäd Rafi: It's administered through finance, so I'll have to get you that. I'm sorry, I don't know.

M^me^ France Gélinas: Okay. I'm curious to see, does the ministry invest any money in research and continuing education or in technology specifically for home care?

Hon. Deborah Matthews: Yes. In fact, we have some pretty exciting projects that are opening up. We put out an RFP to learn more about home care and long-term care, and we had a number of proponents come forward. I think Schlegel and—

Mr. Saäd Rafi: Bruyère and Baycrest.

Hon. Deborah Matthews: —Bruyère and Baycrest were the three successful proponents for knowledge transfer research. So it's about getting better at delivering services so that people are healthier. We can get you more details on those projects. They also involve a training component. At Schlegel, for example, they'll have students from the college and the university doing co-ops and learning on the job.

M^me^ France Gélinas: Can I have the dollar amount? How much do we spend?

Hon. Deborah Matthews: Yes. Specifically on home care and long-term care?

M^me^ France Gélinas: No, just home care. It's coming back. This section will all be on home care, so any money we invest in research, in continuing education and in technology, specifically for the home care sector.

Hon. Deborah Matthews: The other thing, when it comes to research, is that we recently pooled a lot of our research money and we went to the sector, the research communities, and said, "These are the problems we're trying to solve. Can your research help us solve these problems?" And we've been able to allocate research projects that very much are applied—some of them apply to home care, I believe.

1620

M^me^ France Gélinas: Okay, and for the three sites that you have selected: None of them are in the north; certainly none of them are in the northeast. Is there a chance that there will be an expansion of those so that, rather than three, we have four and we include the northeast?

Mr. Saäd Rafi: Yes. That was done through a competitive approach. They're meant to be pilots. They are examining everything from independent living right through to palliative care in a campus environment. The idea was to find whatever nodes qualified in terms of proposals that came forward. We would have selected those. We would have selected nine, if nine qualified. We had three that qualified. It's a pilot project. If we can do

more of that, then that would be another community solution that could be rolled out to other parts of the province. But at the time, that's the response we received.

M^me^ France Gélinas: Okay. How much money has been spent so far on the PSW registry?

Mr. Saäd Rafi: I don't know.

Hon. Deborah Matthews: We will see if we can find that answer for you.

Mr. Saäd Rafi: The registry itself has not really been a huge cost driver. Really, we've been spending our time working with the OCSA, as well as others—and create a steering committee—to determine what would be the criteria and who would house and administer the registry.

We have a transfer payment agreement with OCSA for the 2013-14 fiscal year. My notes indicate here that we have provided $1.07 million to OCSA to maintain and house and administer the PSW registry. As of, let's say, early September in this calendar year, there had been some 32,000-plus PSWs who've applied to register with the registry across all sectors, and 23,000 have been registered.

M^me^ France Gélinas: Is the goal of the registry that it be self-funded?

Mr. Saäd Rafi: I don't know the answer to that. I'm not certain how to necessarily self-fund it, because that would require asking the PSW who participates in it to somehow make some contribution. I don't believe that to be the objective, but rather to help employers and PSWs make connections, as you know, with employment opportunities, because sometimes they can't get completely a full-time work experience.

M^me^ France Gélinas: Okay. How would I find out how much money is being spent in therapy, in nursing and in PSW in home care? Do you know how much we spend?

Mr. Saäd Rafi: I think we know; I do not. But I think we can break that down by PT, OT, and PSW nursing by LHIN for home care. Is that what you're looking for?

M^me^ France Gélinas: That would be perfect. Not as good as getting my voice back, but very good.

You made a 4% increase in the budget for community care. How can I track—where did the money go? Did it all go to CCAC-funded contracts? Did some of it go directly to community-based agencies that get funded by the LHIN? How can I follow that money?

Hon. Deborah Matthews: The community and home care sector: I'll let the deputy find the note, but it includes both home care and community sector, and we do have—

Mr. Saäd Rafi: Yes, so $15 million of the $260 million is going towards wait times for nursing, complex patients, to get to a five-day wait time for nursing services; $60 million is going to wait times for complex clients requiring personal support services to get to a five-day wait. I think we talked earlier that it's skewed that way because the waits are higher for PSW. That's $75 million; $110 million is given to the LHIN and CCACs, as we were talking earlier, to deal with general increase in demand for services of the 623,000 clients who receive home care services today. That is $185 million. Now, I have to remember what the remaining $75 million is going towards.

Hon. Deborah Matthews: Community supports.

Mr. Saäd Rafi: Ah. Community support services. I will get you what that specific amount—

Hon. Deborah Matthews: Those are things like day programs for people with dementia, a range of community supports designed to provide caregivers a range of initiatives to achieve the outcomes that we give to the LHIN.

Mr. Saäd Rafi: Thank you, Minister.

Hon. Deborah Matthews: You're welcome, Deputy.

M^me^ France Gélinas: So you had already given me the 2015-16—

Mr. Saäd Rafi: Yes.

M^me^ France Gélinas: The money doesn't drill down any more than that. This is—

Mr. Saäd Rafi: Oh, no. We can get you that by CCAC or LHIN—same boundaries.

M^me^ France Gélinas: Okay. Thank you. There's been a lot said about the growth in the number of staff in CCACs as well as the growth in the number of clients served. Do you ever keep track of some kind of a ratio between the two?

Hon. Deborah Matthews: What I can tell you is that since 2003, we've increased the number of people getting home care supports by 200,000. We're now at 637,000. We were just over 400,000 and now we're at over 600,000 people getting care through CCACs. Their budget has increased by 92%, so that's $1 billion more we're spending now in home care than we were just 10 years ago.

When it comes to—and I know you're getting to the management, what percentage is management. There's a real difference of opinion on this that I think—if people actually sat down and understood what we were talking about, we'd see about 9% of the budget goes to administration and 91% to the front lines, including care coordinators. I think anyone who diminishes the importance of the care coordinator does not understand how important they are in providing the care that people need in their homes.

M^me^ France Gélinas: When we see statistics being quoted that say the cost of home care is so much per day or so much per patient, what is included in those stats?

Mr. Saäd Rafi: It's sort of akin to the per diem—and by the way, the 2% is on nursing and supports in the per diem for long-term care. You were asking about that. I may have not answered that previous question correctly.

But now back to your question: It's based on the fact that a CMI of 100 in long-term care equals $158 per day, and then you adjust the CMI on average for the home at the end of the year, which could—maybe not ideal, but that's the methodology. I think you heard from Richard Joly when were here in the public accounts committee on the long-term-care home Auditor General chapter that the acuity or the RAI indicator is sort of a baseline, and then one has to adjust based on acuity or the complexity of

need, just like the wait-lists tend to adjust as well because of the complexity of client.

I'm always loath to talk about either money per individual or amount of care by FTE per individual in home care because that doesn't tell the full story of assessment of need and services matched to need as opposed to—the suggestion that it might leave is that it's a cookie cutter or average, and once you expend the average one is done. We're really trying to move away from that kind of a model or methodology.

M^me^ France Gélinas: Okay. Well, I think exactly the way you do, but then I don't understand why we are moving in home care toward—you know, you get so much money for wound care.

Hon. Deborah Matthews: Or for bundled payments.

M^me^ France Gélinas: Yes.

1630

Hon. Deborah Matthews: Because the evidence is pretty good on this, and we're still learning. I think it's fair to say we're still learning. But the wound-care people would say that proper wound care—they really watch the evidence on this a lot. They can heal wounds more quickly if there's a real focus on that wound care. So you could have somebody going to change dressings every four days for weeks on end and the wound doesn't improve, but if we have bundled care—"This is what we're paying for this kind of wound"—then they can figure out the best way to get that person healed as quickly as possible.

Mr. Saäd Rafi: Can I give you another example? With stroke patients, what we see, whether it's—I'm going to botch these terms—hemorrhagic or ischemic stroke, if certain tests are not performed, then a proper diagnosis isn't necessarily given. The length of stay of that individual in that hospital is almost double what it should be for the best-practice length of stay. I think for hemorrhagic it's 14 versus seven days, and for ischemic it's 12 versus five days.

The evidence that we're trying to get across is to say, "We will pay, but we will actually want you to do more procedures. We need testing, and we'll pay for more procedures because it reduces length of stay. By reducing length of stay, it reduces overall cost, but it's also a better outcome." That model, applied to either a bundled-payment model or a bundled-care model, is what we're also trying to do in the community.

You can apply that to outpatient knee replacement rehabilitation or you can apply it to all manners of other things. That's what we're doing in quality-based procedures as well.

M^me^ France Gélinas: So can I expect more of those clinical pathway payments to come down?

Mr. Saäd Rafi: Yes. That's part of our health system funding reform. We're just starting with home care and CCACs. Only, I think, 5% this fiscal year will be applied in that regard. A multitude of expert panels must be struck, with higher representation from community care providers, to help us determine, in a very complex environment which you know well, how to do that in a bundled-care or in a pathway model of care so that we can get better value for money being expended.

M^me^ France Gélinas: Bundled care or pathways: Do they mean the same thing money-wise?

Mr. Saäd Rafi: The methodology? I think, effectively, yes. The lexicon varies. Other people like to use the bundled-payment terminology. My own preference would be "bundled care." It's about the care first, because "bundled payment" suggests that we're trying to squeeze down the spending. Actually, we're trying to right-size the spending in some cases, and a stroke would be a good example.

M^me^ France Gélinas: I used to keep track of how many contracts were out there in home care. It's becoming really hard to find that information. Can I ask if you guys know how many contracts and who has those contracts for home care services?

Hon. Deborah Matthews: Every CCAC would have that information.

M^me^ France Gélinas: They don't share that.

Hon. Deborah Matthews: Let's see what we can find.

Mr. Saäd Rafi: Yes, we'll have to find out if we can get that. It will be a fair bit of work to assemble, but we will ask the CCACs. I don't believe we keep a running tab. I think they're monitoring the performance of those contractors quite closely these days as well.

M^me^ France Gélinas: So if half of the contracts throughout the province were with one single for-profit company, you wouldn't know?

Mr. Saäd Rafi: Would we be aware that that was the case? Probably. I guess that we can debate for some time whether that's a good or a bad thing.

M^me^ France Gélinas: I agree.

Hon. Deborah Matthews: We did change, fairly recently, the competitive procurement process to managed contracts, I think we call them.

Mr. Saäd Rafi: Yes.

Hon. Deborah Matthews: There was a time when a contract would come up and companies would bid on that work. If they lost the contract, they would have to fire all their staff. It was very disruptive for patients and for the staff. We've now changed how we do that, so if a home-care company or organization is providing high-quality care and they're doing a good job, they can manage that contract to continue doing that work. That was a change of policy, because we thought it was better for the clients and absolutely better for staff.

Mr. Saäd Rafi: And we would know, just like in long-term care, when we're transferring, let's say, the running of a home because one provider decided that they can't continue or they have not met compliance, our staff would be aware of the relative breakdown, concentration of ownership. We would look to neighbouring providers to understand that community and ask them to step in to manage a contract until another procurement process could be undertaken—in long-term care, for example. I would imagine the same would be done in home care, per the minister's comments.

The Chair (Mr. Michael Prue): Less than a minute left.

M^me^ France Gélinas: Okay. Did you do any studies to see whether the needed future supply of professionals, specifically for home care—and are those studies available anywhere?

Hon. Deborah Matthews: I believe HealthForce-Ontario looks at our HR within health care. The PSW registry is going to be very helpful in helping us understand who PSWs are, how old they are and how we need to project when they are likely to retire.

This is one of those issues that does keep me awake at night, because we need to make sure as we expand home care—it's not just maintaining the supply of personal support workers; it's actually increasing the supply. So this is very much an area of focus.

Mr. Saäd Rafi: Plus we're also working with OCSA and a couple of other associations that represent what I will call the smaller community agencies to help them with their capacity to take on this funding, their ability to receive funds to provide additional services, because there has been, over the last five or six years, a shift in that funding. They've asked for that, and we're working together to try to assist.

The Chair (Mr. Michael Prue): Okay, wrap it up.

Hon. Deborah Matthews: That was actually one of Dr. Sinha's recommendations, I believe: that we allow these community service organizations to hire PSWs to provide a moderate level of care.

The Chair (Mr. Michael Prue): I'm going to cut you off there. You have half an hour to rest your voice. Twenty minutes now to the government. Mr. Colle?

Mr. Mike Colle: Thank you, Mr. Chair. Minister, I want to ask about some subjects of interest in the community. The first one I want to ask about is the community health centres.

Hon. Deborah Matthews: Yes?

Mr. Mike Colle: I deal with four of them in the general area that I represent. What is happening is that there was an expansion program for a while, and I'm just wondering: Is there going to be continued expansion of community health centres throughout the province or in certain areas of the province? What is the status of the future of community health centres?

Hon. Deborah Matthews: Community health centres play a very, very important role. In large urban centres, they tend to deal with people who face barriers to accessing health care; in rural Ontario, they may look like any other family health team or clinic, but we really believe—I really believe—in that CHC model, particularly for people with complex needs.

It was George Smitherman who announced the greatest expansion ever in community health centres. I think we went from 57 to now 101 sites. I could have that wrong, but that's the magnitude of the expansion. They are doing a terrific job.

We don't have any plans right now to open more CHCs, but as our supply of those primary care providers is stabilizing a bit in most parts of the province, we are not seeing the kind of shortage we used to have. We are looking at the various models; whether it's family health teams, nurse practitioners, clinics or community health centres, there is a variety of models.

I would say the worst is behind us in terms of getting access to primary care, but there's still more work to do. As we identify those areas—and the LHINs are now really giving very good guidance on where there are pockets of underserved areas when it comes to primary care. As that work is done through the primary care leads in each of the LHINs, we will be making decisions about whether we need to have a further expansion of those models or other models.

1640

Mr. Mike Colle: In one of my community health centres, the Anne Johnston health centre, there are, I think, three nurse practitioners. Then I have St. Clair West Services for Seniors; it has opened up, I think, a family health team with three nurse practitioners. I'm just trying to find out, and I guess you answered part of it: Is that going to be the trend, that there are going to be more of these family health teams with nurse practitioners and dietitians, little hubs as opposed to the community health centres? I think what they do is really take the pressure off of emergency and hospitals. I think they're saving a lot of money, because some of the people who go there—not all—have chronic problems. They've got psychological problems, problems with poverty, problems with abuse etc.

I'm just wondering whether or not there might be a model—a hybrid between the nurse practitioner-led—

Hon. Deborah Matthews: Clinics.

Mr. Mike Colle: —health teams, clinics and the community health centres. You don't have to have a big, huge building; the community health centres are usually in older buildings, but you could have smaller, little hubs that provide those core services.

Hon. Deborah Matthews: Yes, absolutely. When I talk about the expansion of community health centres, a good number of those are actually satellite sites. We've had a terrific expansion in nurse practitioners' scope of practice and in the number of nurse practitioners working in the province. I can tell you that when I meet with other health ministers, they want our nurse practitioners because they really see the value of nurse practitioners in the health care system. Nurse practitioners have a broad scope themselves, but they also work with consulting physicians, so if they've got someone presenting who needs care that's beyond their scope, they can easily refer to that physician.

Our community health centres have salaried physicians and other allied health professionals. The family health team model is a capitation model. Physicians are paid by the number of people they care for and the age and health of those people, and we fund the allied health professionals.

Nurse practitioner-led clinics are obviously led by nurse practitioners, but they also have other allied health professionals as well. These are innovative. Community

health centres have been around for a while, but family health teams have just been in the last decade, and nurse practitioner-led clinics are even more recent than that.

Mr. Mike Colle: Just to switch—sorry to be so abrupt, but the next thing I want to talk about is mental health treatment for young adults. I have met with the parliamentary assistant about this issue because there seems to be a dearth of residential facilities for young adults who have mental health issues. The only option for them, in many cases, if they need residential treatment, is to go to the United States, which is extremely expensive. I'm just wondering, as part of the new initiative on mental health, especially starting with youth, whether or not there is any plan to have any kind of residential health centres or an availability of beds in Ontario for young adults who suffer from eating disorders or associated mental health issues, where they have no success treating it with—because it seems to be, with the advocates I've talked to, that what they get mostly is a lot of medication, and the medication doesn't solve anything.

Therefore, the next step, if they've got money, is to go to the States. Then they go to the States; I've heard cases where they spend hundreds of thousands of dollars to no effect, and so they come back here.

Wouldn't it be wiser for us to maybe establish some beds for these young adults, especially, who suffer from these mental health issues here in Ontario? Wouldn't it save money, rather than families having to go to the States or providing them with all these pharmaceuticals that, in most cases, don't solve anything? From what I'm told as a layperson, they seem to mask things. I just wanted your comments on residential treatment centres for young adults.

Hon. Deborah Matthews: You're absolutely right, and I think we all know that mental health has been undervalued in the past. I think that is really changing rapidly.

When it comes to sending people out of country, we watch very carefully where people are being sent, and we know if we see higher numbers of people being sent out of country that that tells us we need to build capacity here. We are, in fact, building a residential treatment centre for people with eating disorders. That is actually happening in London, so I'm watching that very closely.

Not only is it more expensive to send people away, as I was saying earlier, but they don't have that continuity of care. When something like mental health—you know, you can't just go away and expect to be cured and come back all better. It doesn't work that way. You need to have the continuity of care. The follow-up care after that intensive residential treatment is really important.

As we're building our year-four-plus—and you're right to talk to the parliamentary assistant, because she's the lead on the next phase of the mental health and addictions strategy—that capacity within Ontario is something that we're focusing on.

Mr. Mike Colle: Isn't it possible, rather than the government doing it by itself, to maybe partner with a non-profit agency or provider that's already out there, in association with a hospital—I know that Toronto General does work with young people with eating disorders etc. Isn't it possible to look at maybe setting up a couple of pilot projects in different parts of the province—they don't have to be big—to basically give the young people an opportunity to get some residential treatment? Or even day treatment; they could get treatment during the day and they could go home at night, but at least they're getting some kind of comprehensive supervision here.

My fear is that the system is so complex and the ministry is trying its best to deal with 1,001 issues that in this area of mental health for young adults—I'm just wondering whether we could try to put some resources into some partnerships in two or three locations in Ontario where an existing agency would partner with the ministry to essentially provide this residential care.

I've talked to people who are willing to raise money and to get involved in this type of advocacy because they've seen their own daughters, their own sons go through this horrendous mental health trauma, and all is left—you've seen it yourself. I had a friend who was in Northwestern hospital, which is just outside my riding. There's a mental health, psychiatric ward. There are children as young as 10 years of age in it. Believe me, I wouldn't want my children or grandchildren to be in that place, nor would I want—I mean, they try their best and they try all this medication. Do you know what they're still using? They're still using shock treatment. This one person I was visiting—the only thing that helped him get through his severe depression is shock. I've mention that to people and they say, "This was something we used 100 years ago. They're still using shock treatment in Ontario?" But the doctor told me it works. There's sort of a refined process of using shock treatments.

The reality of seeing people in these conditions in these hospitals or in these care facilities is quite frightening, and that's why I'm glad that we're bringing this out into the open finally. I think we've got to start to maybe look at these smaller models and to get help to people when they're younger so they won't get into this chronic depression that lasts for years and years.

I started to extrapolate into the other issue, but I'm just wondering what your comments would be on that.

1650

Hon. Deborah Matthews: No, absolutely, and I think the deputy has some examples of—

Mr. Saäd Rafi: I think you're right. Early intervention is something that the Ministry of Children and Youth Services and the Ministry of Health and Long-Term Care are working on together. Some of that is in the first three years, the mental health strategy, so for example, every school board providing social work and mental health workers to help early identification and behaviour challenges so that we can make sure that youth are properly channelled. But in addition to that, there are partnership opportunities, to your point, with not-for-profit, but also I think there has been a very strong response from the corporate sector in many different subsectors.

Mr. Mike Colle: Bell Canada is—

Mr. Saäd Rafi: Bell Canada is, yes, a very notable example. While that may be focused a little bit more on the adult side of things, in addition to that, the Council of the Federation of Premiers met, and mental health is an identified area of priority by Premiers Wynne and Selinger. Manitoba is taking the lead, but there will be a mental health summit bringing not-for-profit, for-profit and government representatives together, hopefully before the end of the calendar year, to talk about how there can be a joined-up effort to manage what is an increasing affliction and challenge that is coming to the fore more and more as people are beginning to talk about these issues, as you pointed out.

Hon. Deborah Matthews: If I could just add, because I can't let your reference to shock treatment go—

Mr. Mike Colle: There's a fancy name for it, but it's—

Ms. Helena Jaczek: Electroconvulsive therapy.

Hon. Deborah Matthews: It's a lot different now than it was before. There was a very thoughtful article recently published in the Toronto Star, in response to an article that was pretty harsh, from two physicians at CAMH who have very good evidence that for some people—some people—it actually saves their lives. I just think it's important that we not stigmatize that kind of therapy, because it is effective for a small subset of people facing depression, I think, in particular.

Mr. Mike Colle: Yes. As I was saying, in this case it helped the person that I was visiting. It did help. The doctors told me it was the only thing that saved the person, and thank God, touch wood, he's still back in good health.

We have group homes across the province that deal with people with cognitive disabilities, with physical disabilities. They're run by the Reena Foundation, all kinds of wonderful organizations. I'm just wondering why we can't use that model, where there's a home or there's a building where people have their dinner, their lunch, they sleep, and then they have professionals, they have caregivers in that group home setting. I don't know, for the life of me, why we can't use that same group home setting and have mental health professionals in that setting that help—I'm talking about young adults—them get through the trauma of this mental health illness they're going through. Is it the shortage of expertise? Because they're going to end up in the hospital anyway, or in the States, where it costs a fortune. Why can't we use that group home model with the mental health nurses and the psychiatric supports? Why does it take so much to have a residential care facility for young people?

Hon. Deborah Matthews: We actually do have—we can get you the number—thousands of supportive housing for people with mental health challenges. In fact, we recently announced the funding of over 200 more through a pilot program started by the Canadian Mental Health Foundation called At Home/Chez Soi. It was focused on people who were homeless. It got them into housing, got the right supports—a wonderful, wonderful success measured in many different ways, including visits to emergency departments and involvement of the police. So there's a growing understanding that that kind of supportive housing is absolutely the way to go.

We opened the YWCA down on—I want to say Oak Street, but it's not Oak Street, but not far from here. It is supportive housing for women, so that is—

Mr. Mike Colle: Grosvenor?

Hon. Deborah Matthews: It's not on Grosvenor. I'll—

Mr. Saäd Rafi: It's the YW.

Hon. Deborah Matthews: Yes, it's the YW. Because if people don't have a home, it's very, very hard to move forward with any kind of treatment to get them back on—

Mr. Mike Colle: And I think that's laudable, especially because a lot of people who have homelessness issues are suffering from mental illness and psychological challenges.

I'm just wondering, why not have a similar thing like you did for the homeless for the young adults—you know, young women or young men—who have these mental health issues? So you get a segment from 18 to 24, whatever it is, who are put in a group home setting with the mental health professionals helping that very targeted group, rather than waiting for these residential care facilities or beds which we don't have and seem so long in coming. I can't see why we can't use that model.

Hon. Deborah Matthews: So we can and we do—

The Chair (Mr. Michael Prue): You have about 20 seconds.

Hon. Deborah Matthews: We can and we do, and I'm hearing you say you want us to do more.

Mr. Mike Colle: Yes, for that group, and as soon as possible because we can't wait for—

Hon. Deborah Matthews: Exactly.

The Chair (Mr. Michael Prue): Okay, we're into the 10-minute round now, starting with the Conservatives.

Mr. Rob Leone: Thank you, Mr. Chair.

Minister, just piggybacking a little bit on what Mr. Colle was asking you about, I know mental health has been an issue that certainly a lot of people have considered a priority. Certainly, I think all parties have suggested that we need to do more in the area of mental health. Are there any charts or documents that you could provide showing how money is shifting into mental health, how much more the government is spending and how many more programs in mental health are now available, given this switch in focus? I know part of your transformation document talked about that. So is there any concise detail in terms of how much money has shifted into mental health and what programs have been created as a result?

Hon. Deborah Matthews: We can prepare that for you.

Mr. Rob Leone: You can provide that. Okay, thank you very much.

Hon. Deborah Matthews: I'm assuming you're talking mental health and addictions.

Mr. Rob Leone: Exactly. Yes, absolutely.

I have some estimates questions with regard to the estimates that you have produced. I know we're going to be voting on the estimates by the end of the session today. I noticed for your health policy and research program, the difference between what you spent in 2012-13 and the estimates of the spending this year is some $120 million more—almost $129 million more—than the year previous. Where is that money going and where is that money coming from?

Mr. Saäd Rafi: Do you have a page reference by any chance?

Mr. Rob Leone: Sorry, I'm in the expenditure estimates, on page 273 of this book.

Mr. Saäd Rafi: I suspect I have a different version. I do. We'll have to get you that—

Hon. Deborah Matthews: Here it is.

The Chair (Mr. Michael Prue): Could you let us all know what page it is in that book? Because that's what most of us have.

Mr. Rob Leone: It's line 1402.

Mr. Saäd Rafi: Page 81.

The Chair (Mr. Michael Prue): Page 81?

Mr. Saäd Rafi: I believe, yes.

Mr. Rob Leone: Sorry. Hopefully the numbers are the same—the $129 million. I'm just wondering, what is that money being allocated to in the health policy and research program? It's a lot of money.

Mr. Saäd Rafi: I'll have to get you a reconciliation as to why there's an increase, because I would have to look at the previous year's actuals to these estimates to understand which one of the line items on this page has gone up to account for this total change.

Mr. Rob Leone: So there isn't any new initiative—

Mr. Saäd Rafi: I don't—

Mr. Rob Leone: —that would account for—I mean, that's a lot of money.

Mr. Saäd Rafi: It's a lot of money. I don't know off the top of my head—

Mr. Rob Leone: I would assume that must be some new research program or some more—what does the health policy and research program do, specifically?

Mr. Saäd Rafi: Well, first off, this area is on a base, in 2013-14, of $966 million, so it is a 15% increase, as the previous page shows. You can see that the elements are—

Hon. Deborah Matthews: So it's clinical education, primarily; that's the big increase.

1700

Mr. Rob Leone: So there's no one thing that sticks out in your mind as to why it would be that much bigger?

Mr. Saäd Rafi: No, sorry, but I'll get you that information.

Hon. Deborah Matthews: On page 80, you'll see that the clinical education line is up by 16.2%. So that is training doctors and training nurses—internationally educated doctors and nurses as well.

Mr. Rob Leone: Your eHealth and information management program costs are going up by $34 million there. Any particular reason for the increase?

Mr. Saäd Rafi: Again you're on page—

Mr. Rob Leone: I'm not in the same book, but it's line 1403 of the estimates that we'll be voting on. Next time we'll coordinate the books we bring.

The Chair (Mr. Michael Prue): That would be page 86 and 87—I think it is.

Mr. Saäd Rafi: Thank you.

Mr. Rob Leone: But nothing particularly stands out for eHealth, $34 million—almost $35 million—more?

Mr. Saäd Rafi: If you could bear with me—are we looking at the same thing? I have a change from 2012-13 to 2013-14 of a reduction of $53 million. Maybe I'm looking at something different.

Mr. Rob Leone: No, I have a different—it's going to be interesting when we vote on this. I don't see that reduction at all.

Mr. Saäd Rafi: Oh, I see. Sorry, pardon me. Yes, the bulk of those costs—in fact, almost entirely, except for a reduction in agency efficiencies at eHealth Ontario—comes from the implementation of something called Community Care Information Management, which is using tools such as back-office support for thousands of community agencies and the RAI-MDS tool that we talked about, the resident assessment instrument, that's used in long-term-care homes and home care.

This is a multi-year rollout of those tools for thousands of health care professionals in the community sector to do the assessment—that's on page 90; you'll see the reference to CCIM investment—to allow them to have a more up-to-date and more consistent assessment of the acuity needs of home care recipients.

Mr. Rob Leone: Okay. Now, it says the Ontario health insurance program is going up by about half a billion dollars; that's probably for demographic reasons, I'm assuming, and we're likely going to see increases of that magnitude for the foreseeable future, I'm assuming.

Hon. Deborah Matthews: Our recent negotiations with the OMA and OHIP include more than just the physician compensation, but we are working very hard to actually hold the line on physician compensation, because we feel that there are other demands in our health care system that we must invest in.

Mr. Rob Leone: That physician compensation is about $12 billion, right? I saw that number somewhere.

Mr. Saäd Rafi: No. Actually, that includes all manner of health professionals who might be billing fee-for-service. That would include physiotherapists at a couple hundred million, because we're trying to reduce those costs that were escalating $50 million above budget. Approximately $11.1 billion of the 12-and-something billion dollars are due to fee-for-service physicians.

Mr. Rob Leone: Okay. The public health program is getting a bump of about $46 million, from $715 million to $761 million. I'm just wondering why the increase of almost $50 million for public health, and if there are particular initiatives that the public may need to be aware of.

Mr. Saäd Rafi: Generally, public health is funded at a 75% contribution from the province to municipalities, and they contribute 25% of the budget. Now, that is not

what's causing these increases. The bulk of the $46 million, as you can see in the blue book on page 129, is for the increased investment in vaccines. We work with the federal government to ensure that we have the right stockpiling of various vaccines.

A good example has been what Alberta has run into with the measles outbreak that they have in certain communities in Alberta. The federal government is the purchaser, and we keep a stockpile and pay for those vaccines. That's $30.5 million of the $46 million. There is some related mandatory program growth as you can see there.

Panorama project investment is a national immunization IT project that is being implemented with, I think, seven or eight provinces across the country, where, again, public health units are using immunization methods to track whether students in school, especially grade schools, are being immunized. This is proving to be an effective program.

Mr. Rob Leone: Finally, there are lots of other things we could talk about, but the provincial programs and stewardship getting an increase of about $77 million—any particular reason for that increase?

Mr. Saäd Rafi: Provincial programs are a good example of activity-based funding. So it really varies on the volumes that hospitals do in certain designated areas. That's reconciled at the end of the year. You can see it's a fairly significant base of $3.87 billion in 2012-13, with a 1% increase, which is representing that $43 million. So a 1% variation on the multitude of programs that would be in place would not be anomalous from previous years.

But I would point out that there are a lot of ins and outs in this calculation. There are some physician services agreements with the OMA, efficiencies through evidence-based changes that would be—for those who have the blue book, on page 152—$61 million. That's a material number. Post-construction operating would be funded out of this, which is to pay for the operating ramp-up after new or redeveloped hospitals are being built. That has been a fairly aggressive program for the government over the years, and you can see that that accounts for $126 million. Again, a notable decrease would be the hospital working fund initiative, which is taking hospital deficits on a—using lines of credit and helping them work through that debt that they're carrying, getting that off of their books and therefore the government's books, through consolidation. That represents approximately $66 million. Of course, community services–investments in services for leasehold improvements—and I'm getting the hook—for $210 million.

The Chair (Mr. Michael Prue): Okay, I just wanted you to finish your sentence, and you did.

Mr. Saäd Rafi: Thank you.

The Chair (Mr. Michael Prue): The next 10 minutes go to the NDP.

M^me^ France Gélinas: We'll be very quiet. We'll try to talk about nurses. Do you keep track at all of the uses of agency nursing throughout the health care system, or is this something you don't look at?

Mr. Saäd Rafi: I hate to ask a follow-up, because it's—

M^me^ France Gélinas: Go right ahead.

Mr. Saäd Rafi: Agency nursing refers to a temp type of service?

M^me^ France Gélinas: Yes.

Mr. Saäd Rafi: I'm not sure if we follow that. There was an initiative that—I think a question was asked in late 2011 where we did hire more at the case-management level. CCACs felt that they could benefit from hiring nurses in those areas as opposed to going, for example, through the contractors. But I don't know of tracking—I'd have to check.

Hon. Deborah Matthews: You're talking about individual hospitals, how much they rely on agency nurses? And home care and long-term care as well?

M^me^ France Gélinas: Yes.

Hon. Deborah Matthews: I don't know if we track that. We'll find out.

M^me^ France Gélinas: If you do, I would be interested in knowing where they are being used and if their usage is increasing. From my observations on the ground, we see them more and more in places in the health care system where it's quite surprising to find out that they're agency nurses.

Hon. Deborah Matthews: One of the commitments we made way back in 2003 was to increase the proportion of nurses who work full-time. I think the nursing sector said that about 70% was the right balance. We have gone from, I think it was 50%, to very close to 70%. So that might be part of the answer to your question.

M^me^ France Gélinas: That's in hospitals. The 70% doesn't apply to long-term-care homes or to other areas.

Hon. Deborah Matthews: That's correct.

M^me^ France Gélinas: But the agency nurses—

Hon. Deborah Matthews: The 70%—

Mr. Saäd Rafi: Well, that data is from the college so it may be beyond hospitals. It's not an ONA member. So I don't know. I don't think it's just hospitals.

1710

M^me^ France Gélinas: Okay.

Hon. Deborah Matthews: We'll find out.

M^me^ France Gélinas: We'll find out.

Mr. Saäd Rafi: We're at 66.6%, according to the college of nursing.

M^me^ France Gélinas: Right now?

Mr. Saäd Rafi: It's full-time employment, yes.

M^me^ France Gélinas: Okay.

Mr. Saäd Rafi: Which is a 17% increase in 10 years.

Hon. Deborah Matthews: Seventeen percentage points, which is like about a 35% increase.

Mr. Saäd Rafi: True.

M^me^ France Gélinas: She's strong in math.

Mr. Saäd Rafi: Very, believe me.

M^me^ France Gélinas: We have 9,000 net new nursing positions that were announced some time back. Are we there? Was this a success, and do we know the breakdown between RNs and RPNs?

Hon. Deborah Matthews: We have definitely exceeded 9,000 nurses—

Mr. Saäd Rafi: Ten thousand five hundred.

Hon. Deborah Matthews: Ten thousand five hundred more nurses working now. I think that number has actually even gone up—

Mr. Saäd Rafi: It has gone up since. That's 2012.

Hon. Deborah Matthews: —since then. There are—and I'm going by memory here—more RPNs. The growth in RPNs has been faster than in RNs, and then there has been a very significant increase in nurse practitioners. So as the nurses get trained up to become nurse practitioners, they move from the RN into the NP category.

M^me^ France Gélinas: Who tracks those numbers?

Mr. Saäd Rafi: We work with the College of Nurses to do that, and we are constantly in discussions with the RPNAO, the RNAO and the ONA, because the issue of the absolute growth in various elements of the nursing profession sometimes belies the ratio of nurses to RPNs, which is tracking where it should be, based on feedback from the college as well as the unions.

M^me^ France Gélinas: So are there actual studies that look at what the mix should be between RNs and RPNs?

Hon. Deborah Matthews: Yes. The answer is yes. Hospitals are making changes to their staffing mix based on evidence.

M^me^ France Gélinas: Where are those studies?

Hon. Deborah Matthews: Let's see what we can direct you to.

M^me^ France Gélinas: Okay. So, of the 10,900, the number from 2012 that you quoted, will I be able to get a breakdown as to how many were NPs, RNs and RPNs?

Mr. Saäd Rafi: I think so, yes.

M^me^ France Gélinas: Okay, thank you. In May 2012, you announced 900—do you remember that?

Mr. Saäd Rafi: New nurses.

Hon. Deborah Matthews: New nurses? Yes.

M^me^ France Gélinas: Yes, new nurses. Are those captured in the 10,900?

Hon. Deborah Matthews: I would have to check. Probably not.

Mr. Saäd Rafi: Not likely.

Hon. Deborah Matthews: Well, we'll make sure. We'll reconcile that.

M^me^ France Gélinas: Okay. With the same idea of a breakdown?

Hon. Deborah Matthews: Oh, I've just been told I have the numbers. We have 7,935 more RNs. We have 7,019 more RPNs, and that's an increase of 27%. We have a 250% increase in NPs, so that is 1,339 more NPs. So when you look at all nurses, it's 16,293 more nurses working in the province, and this is from the College of Nurses.

M^me^ France Gélinas: Okay. What's the date on that?

Hon. Deborah Matthews: The date on this is 2012. So it's the 2012 CNO membership statistics report.

M^me^ France Gélinas: Okay. Before my 10 minutes run out, or my voice runs out—I think that's already gone. I wanted to talk to you about Hamilton Urban Core Community Health Centre. Where are things at with the request for funding for a capital project for them?

Hon. Deborah Matthews: The LHIN is looking at the services offered by Hamilton Urban Core. You probably know that that area of Hamilton has a lot of different community agencies located within that urban core area. The LHIN is taking a look at what would be an appropriate addition, if any, to the services provided at Hamilton Urban Core, so the LHIN is doing a review now of Hamilton Urban Core.

M^me^ France Gélinas: When is this review going to be completed?

Hon. Deborah Matthews: By the end of November.

M^me^ France Gélinas: By the end of November.

Mr. Saäd Rafi: That's our goal.

M^me^ France Gélinas: And for decisions made?

Hon. Deborah Matthews: On capital? So the first step is to determine what services ought to be offered there, and then a capital request would be considered within the context of that information.

M^me^ France Gélinas: All right.

The Chair (Mr. Michael Prue): One minute.

M^me^ France Gélinas: Okay. I'm back with nurses. You've talked about some of the studies that were done, either by HealthForceOntario or the nursing secretariat, regarding the skill mix changes. Are you going to make those studies available?

Hon. Deborah Matthews: Let me find out what there is. Let's find out and refer you to the studies.

M^me^ France Gélinas: Are they specifically for a hospital, or do they look at long-term care, home care and other areas where different levels of nurses work together?

Hon. Deborah Matthews: My understanding is it's specific to hospitals, but let's—

Mr. Saäd Rafi: Yes, there's also on—maybe not the skill mix but the supply, so that would look across the entire health sector.

The Chair (Mr. Michael Prue): And I'm going to have to stop you there.

Okay, the last 10 minutes: Ms. Jaczek.

Ms. Helena Jaczek: Thank you, Chair. I would like to go back to talk a little bit more about LHINs. Each LHIN, as you've described, obviously has the responsibility to ensure that the various health care providers, institutions and organizations in their geographic area are working better together, making sure there's more integration of services so that, from the patient perspective, service can be as seamless as possible. I think we understand that.

I'm obviously very conscious of what's happening in my own LHIN in York region, Central LHIN. We're aware of some really quite innovative practices that are occurring within our LHIN. You happened to mention transportation and seniors, and the Community and Home Assistance to Seniors program, which has been in existence for a long time in York region. It is really, I would say, a best practice.

So when a LHIN becomes aware of a best practice or something that they want to share—and I guess from the perspective of the ministry having some need to ensure that Ontario has some uniformity in terms of best practice—how does that information surface? How does it come up from the LHIN? How do they share information? And how does the ministry ensure that best practices then get disseminated? Can you talk to us a little bit about that?

Hon. Deborah Matthews: Sure. I'll start, but then I'll turn to the deputy.

The LHIN chairs and CEOs meet together regularly—I think about every six weeks—and one of the things they do is share their successes and their challenges, so we are constantly trying to provide that cross-fertilization. We do want to provide equal access to care across the province, but we also recognize that communities are different, and the needs and the existing resources are different within the LHINs.

But in terms of, as you say, a best practice where the evidence is demonstrating that this is helping outcomes for patients, there is the opportunity to share that information at these meetings. Perhaps the deputy could—

Mr. Saäd Rafi: Sure. So the ministry management team and the LHIN CEOs meet every month for a full day, and have done that now for almost four years, since my arrival to the ministry. The agenda is jointly set. The chairing of the meetings rotates between our ADM responsible or one of the LHIN CEOs. The point of those discussions is to go over initiatives that they are working on, that they are, in some cases, leading in their communities on behalf of all the LHINs and vice versa, if the ministry is bringing an initiative forward.

1720

In addition to that, whenever we are looking at an expert panel or expert input, we have typically asked for two LHIN CEOs to self-select to be part of a panel, a steering group, a working group or what have you, so that they can report back in on the progress of that particular initiative—health system funding reform is a very good example—to their colleagues across the province. That cross-fertilization of both participation in planning accountability but also the development of initiatives has been a hallmark of the interaction between the ministry and the LHIN, and the LHIN with their health service providers. They themselves might take the initiative to organize their health service providers and create a committee on ALC issues and bring the examples that the Toronto Central LHIN might have had to Mississauga, to Halton etc.

Ms. Helena Jaczek: In other words, there really is a cross-fertilization of ideas, knowledge transfer and an attempt—obviously, I'd say quite a concerted attempt—to ensure that the knowledge is spread across the province.

Hon. Deborah Matthews: One of the really good examples that comes to mind is Home First. Home First was the brainchild of one CCAC working within the LHIN. They demonstrated the evidence that they could reduce ALC rates, that people could, in fact, get stronger once they got home, and that idea—I believe it was the Waterloo Wellington LHIN, but I'm not positive. As they got the results, they shared with their LHINs, and now I think we have the Home First philosophy right across the province. I have to say, people in other jurisdictions are watching it very, very closely.

Ms. Helena Jaczek: Okay, thanks. Just this morning, we heard from you that there are now nine million Ontarians who have an electronic medical record—

Hon. Deborah Matthews: Yes.

Ms. Helena Jaczek: —up from seven million. So we're obviously making progress rolling that out. I know my colleague wants to jump in here for a minute, but perhaps you could just—you obviously demonstrated some of the benefits. Could you just go through again how this is seen from the patient perspective?

Hon. Deborah Matthews: Patients have high expectations of their providers to have the information they need to make informed decisions about the care they receive. I suspect you've heard from constituents who might complain that they have to give their information over and over and over again. That shouldn't happen, and with an integrated health record, it doesn't happen, because all of the providers can actually access the information so they know what tests have been performed, they know the lab results and they know the procedures that have been undertaken. They've got that shared knowledge.

If you think about our health links and trying to pull together this quite diverse array of health care providers, they all need the same information in order to make the right decisions for patients. EHealth is so much more than just electronic records within one doctor's office. That's the foundation; you need to have that. But we're starting to see family health teams that are mining the data from their electronic health records to, for example, notify patients that they are at a high risk for flu—"Come on in and get your flu shot"—and they've seen a huge increase in the uptake of flu shots because they've identified those people who would benefit most and have been proactive about getting them in. So there's the sharing of information across providers and really understanding what's going on with patients within their practice.

The Chair (Mr. Michael Prue): Mr. Dickson.

Mr. Joe Dickson: I've got about a minute, Mr. Chair?

The Chair (Mr. Michael Prue): About a minute and a half.

Mr. Joe Dickson: Thank you. Madam Minister, a couple of quick questions on eHealth. I've gone through a couple of experiences myself. One of them was about 10 years ago. I was out in the country and I didn't feel well. I got myself into town. There was a doctor there who served a wide area of the country, and I didn't even know he knew what a computer was. He sat me down and, of course, as soon as he typed in my name he started calling me Joe and said, "By the way, you've had a heart attack. It's a good thing we have these eHealth records."

This was 10 years ago. He said, "If I didn't know that when I went to prescribe the medication, I could have had some challenges."

Hon. Deborah Matthews: Wow.

Mr. Joe Dickson: It's very, very important. I said, "I'm truly impressed, Doctor."

I just went through another one—pneumonia, pleurisy and a lot of other things; just getting rid of it—and I had some congestive heart disease. I ended up in the Bancroft hospital. Everybody under the sun was absolutely wonderful. There was eHealth written over everything, from an ambulance to the hospital to the time you get in. The doctor stayed there halfway through the night. With the assistance of eHealth and everything on the computer, in due course it will be resolved, now that I've got another cardiologist involved and all those good things.

I guess my only question is: There has been such great progress; where do we go from here, with the significant increase in the number of doctors that you alluded to earlier, when it comes to the medical profession, Ontario hospitals and eHealth in general? I'm sorry; I didn't leave you much time for an answer.

The Chair (Mr. Michael Prue): You left her about 10 seconds.

Hon. Deborah Matthews: The one word is interoperability, so that when you go to a hospital in Bancroft, they can access your records, not just at your own local hospital.

Mr. Joe Dickson: It was wonderful; absolutely wonderful.

The Chair (Mr. Michael Prue): And I thank you.

Mr. Joe Dickson: Thank you, Chair.

The Chair (Mr. Michael Prue): This concludes the committee's consideration of the estimates of the Ministry of Health and Long-Term Care. Standing order 66(b) requires that the Chair put, without further amendment or debate, every question necessary to dispose of the estimates. Are the members ready to vote? I'm seeing a few nods; we'll put that on the record.

Shall vote 1401, dealing with the ministry administration, carry? Carried.

Shall vote 1402, health policy and research, carry? Carried.

Shall vote 1403, eHealth and information management, carry? Carried.

Shall vote 1405, dealing with OHIP, carry? Carried.

Shall vote 1406, public health, carry? Carried.

Shall vote 1411, LHIN and related health services providers, carry? Carried.

Shall vote 1412, provincial programs and stewardship, carry? Carried.

Shall vote 1413, relating to information systems, carry? Carried.

Shall vote 1414, health promotion, carry? Carried.

Shall vote 1407, health capital, carry? Carried.

Shall the 2013-14 estimates of the Ministry of Health and Long-Term Care carry? Carried.

Shall I report the 2013-14 estimates of the Ministry of Health and Long-Term to the House? Agreed? Agreed.

That would conclude us. Thank you, Madam Minister, on your birthday, for being here. We're going to have a two-minute recess until the next minister, Minister Murray, arrives. We are recessed for approximately two or three minutes.

The committee recessed from 1729 to 1732.

MINISTRY OF TRANSPORTATION

The Chair (Mr. Michael Prue): We are here today for the consideration of the estimates of the Ministry of Transportation for a total of 7.5 hours. The ministry is required to monitor the proceedings for any questions or issues that the ministry undertakes to address. I trust that the deputy minister has made arrangements to have the hearings closely monitored with respect to questions raised so that the ministry can respond accordingly. If you wish, you may, at the end of your appearance, verify the questions and issues being tracked by the research officer.

Any questions before we start?

Ms. Carol Layton: None, thank you.

The Chair (Mr. Michael Prue): No? Okay. I am now required to call vote 2701, which sets the review process in motion. We will begin with a statement of not more than 30 minutes by the minister, followed by statements of up to 30 minutes by the official opposition and 30 minutes by the third party. Then, the minister will have 30 minutes for a reply. The remaining time will be apportioned equally amongst the three parties.

Mr. Minister, for the next half hour, or up to that, the floor is yours.

Hon. Glen R. Murray: Mr. Chairman, thank you very much for your hospitality, and it's great to be here with my colleagues. I'll just turn it over. Deputy Minister Carol Layton, I think, is a well-established and well-regarded member of the public service, and she'll be joining me today. Is there anyone you want to introduce?

Ms. Carol Layton: Actually, we have just a few folks here today, because we do appreciate that we're in tomorrow late afternoon for a longer session. We have our director of communications Kimberley Bates observing today and Tom Harmantas who is a special adviser with my office, and they're right there.

Hon. Glen R. Murray: What I would like to do, Mr. Chairman, with your permission, is just give a bit of an overview of the ministry, some of the major issues that we're thinking of, which I hope will help frame the conversation. I'm sure there will be many issues that my colleagues here today will want to raise and discuss, given the criticality of transportation to our economy and our quality of life.

As you may know, our transportation assets right now, if you had to replace them, are worth $80 billion. Governments present and past in Ontario of all political stripes can take great pride in a very strong legacy of investment in transportation.

Part of the challenge we've had is that for the last 50 years, though, through fiscal prudence or for whatever

reason, we were investing, from almost the 1970s on, at a much lower level than most other provinces. We are now spending about 400% more than our traditional level. Our average infrastructure spend right now is about $14 billion. About half of that is transportation.

Every day I'm sitting in question period, Mr. Chair. I have one MPP from almost every party sending me a note, saying, "Can you do something about Highway 6?" I've kept a running total. We are now in the billions of dollars, quite seriously, of requests that I have just accumulated in the nine months I've been transportation minister, from casual notes sent to me by my colleagues on the government side as well as in both the opposition parties. I think that's a strong indication that there is a great deal of unmet need. To meet the need of issues, whether it's in Algoma–Manitoulin or Simcoe North, you would have to almost double the budget. None of the questions I'm getting for rural roads, highways, bridges, issues of transit and transportation, critical water and sewer infrastructure, as Minister of Infrastructure—none of those are frivolous expenditures.

I think we need, in a very non-partisan way, hopefully—because I think this is an issue that should not divide us on ideological lines. I think the opportunity with a minority government to advance the infrastructure agenda is one of those things that, regardless of your ideology—I think all of us can see it is a foundation for our quality of life, for our social justice, our economy, our mobility, our environmental health and our well-being.

We are involved in transportation investments from Cornwall to Kenora. They're very, very critical. Whether it's in our large cities, whether it's Ottawa, Toronto, London or Windsor, there are major roads, parkways and transportation projects under way.

Our transit investments have emerged as one of the most significant, largely because they are so foundational and impactful on every transportation choice, especially for people who are not transit riders. Since we've come into government, we've built on a tradition of investment in transportation. Almost $20 billion alone have been spent in transit investments.

To understand why that is as much for people who are motorists as it is for transit users, the analogy I often use—and I think that probably all of us have experienced it—is if you look at the 401 as it goes through Toronto and heads out to Guelph or Kitchener or Cambridge, it's up to 18 or 20 lanes wide. It's pretty hard to imagine that we could add more lanes to that highway. It's problematically large already.

If you look at the other major east-west carrier in southern Ontario, it's really the Queen Elizabeth, which is about four or six—at most eight, in very rare instances—because half of that traffic is carried on the GO system.

Part of what we're trying to move to is to integrate both highway and GO—higher-order transit systems—because we know that the reason we have fewer lanes of traffic and a little bit more mobility on some of those routes is because we've been able to manage a good modal split between the two.

But the behaviours are very different, and maybe I can illustrate one of the most dramatic in this issue between transit and transportation investments.

Anyone who has gotten on the Gardiner in the morning or gotten on the Queen Elizabeth Way out to Hamilton or out towards London will notice that, certainly in the suburban 905, the traffic is pretty balanced in the morning, by car, going in and out. You've got as many people leaving downtown Toronto now as you have coming into it. But if you go on the GO service, the GO service is oversubscribed—crowded, shoehorned in—coming in at rush hour. But it goes out empty—less than 20% ridership from central Toronto out. Why such a difference? Why congested or full-capacity highways both ways, but GO over capacity coming into Toronto and under capacity going out of Toronto? The reason is that you can actually take a train to a central destination. There are clusters of employment in central Toronto. If you're living downtown, you drive your car if you work in Mississauga or Kitchener or Cambridge because the destinations—the employment land—are very diffused, very spread out.

1740

So one of the things that we're trying to integrate—and I think, again, given that smart growth has continued to governments before, the smart growth movement—our government has embraced it and previous governments have embraced it, under the NDP and under the Conservatives—is something we're trying to move up, because connectivity cannot solve our transportation problems.

Our first line order of improving transit is actually complete communities in proximity so that people can live, work and play in a single community. In Ajax or Pickering, we're working with mayors right now to integrate land use through Places to Grow and with official plans to put concentrated employment clusters along our subway lines and along our GO lines; in Ottawa, with the Confederation Line. We're trying to intensify commercial development so that no matter where you live—that all of those cities and communities, all along our GO lines, as we move to two-way service, can actually have commercial centres, and to try to ensure that we've got proximity, that most of our employment lands are clustered around our higher-order transit, whether it's subway or GO. There are huge opportunities now with the Vaughan-Spadina subway line. We have real challenges getting out to those areas.

In other areas, the highway investments are important, whether it's Highway 6 or Highway 7 or Highway 427; those are critical priorities. Across the north with our highway system—we realize that our highways are also our trade routes. One of the things that has happened since free trade has been a battle for the east-west trade route. The interstate system in the United States is quite powerful, and we have to compete with that. So one of our priorities has been accelerating the twinning of our TransCanada highways, especially the 11 and 17, to get

four lanes, because we want more commercial traffic to go north of 49 and north of the Great Lakes from Toronto to Winnipeg to Calgary and Vancouver. Now, since free trade, about two thirds of it is connecting our major Canadian cities through the US. That means more truck service, more regularity, more logistics and more advantages for businesses south of the border, which have more access to more immediate and frequent transit. We're working very hard. When we met in Winnipeg as transportation ministers, particularly Manitoba, Alberta and Quebec have pressed very, very hard for a national highway program to do that.

It's also essential, in the infrastructure, to open up the Ring of Fire, because it's not just getting things in and out of the Ring of Fire; it's getting them in and out of Ontario and to export markets.

Right now, we are facing a number of challenges because as I said, we're between $6 billion and $7 billion a year now on transit investments alone. We spend more on highways than just about anything else in the transit portfolio traditionally, but we're also up against a very fundamental loss to the economy in productivity and jobs. There is far too much money in Ontario—and this is particularly true in Toronto but not limited to it, if you've been out down the 401 communities: Too many businesses are paying drivers and workers to sit in traffic and burning fuel for vehicles that are not moving. If you believe the Toronto board of trade's numbers, it's $6 billion. If you believe the C.D. Howe Institute, that is between $8 billion and $11.4 billion in lost productivity. That translates into money coming out of working families' wallets. It's increased costs of businesses. It's money that is going neither towards creating jobs, improving services, nor making profits that can be reinvested for future economic growth.

We view that as critical. We have tried to find a jurisdiction somewhere in the world that has managed to do the kind of transit and transportation build in highways and transit that we require without finding a new revenue source. I have yet to find one. I have looked carefully at Chicago, New York, Vancouver, Paris and London. Nor has anyone done it without some broad-based revenue source.

The Big Move: Right now we are about $17 billion into—and I want to emphasize this—about a $50-billion capital project. That is the capital components of it, the hard concrete, rails, tracks and switching systems that have to be built. That will significantly improve the trajectory that we're on.

But it's not like you do the Big Move and end. We're looking at a century where we're going to have to invest more significantly in roads and highways.

Rural roads and bridges are critical. We started the MIII program because of criticality. During years of downloading—and this is not a political shot at anyone; it's just the simple reality, and it went on for quite a long time by different orders of government—many municipalities in rural Ontario picked up a lot of highways and roads that they don't have the capacity for nor do they have the tax base because of sparse populations to sustain.

We've been working very, very hard—and when I say "we," I don't just mean the government. I think there are many positive suggestions coming forward in the Legislature to look at new funding partnerships because a culvert that is in a poor state of repair that has to be replaced can mean cutting off the main street of a small town from a critical highway. A link connecting a community to a major highway system is the lifeblood for those communities.

So a lot of work has been going forward. I know John Yakabuski and Mike Mantha particularly have been very creative in working with us and moving that forward.

I won't go through all of the projects, but one of the things that I think has been a very helpful tool as we go to a more data-rich system for measuring transit and transportation is the good work that we've been able to do with the Ontario Good Roads Association, where we are taking the measure and stock of every rural road and bridge, we are coming up with a financing and sustainability plan to try and use our commitments right now to annualize funding but to use these asset-management plans that have come out of that kind of research where every municipality, small and large, has a plan that has inventoried—looked at the criticality of its infrastructure and provided a bit of a contract between the provincial government and the municipality on how that money could be spent. So we're moving more and more towards funding the plans of municipalities and letting them decide what the critical projects are.

I've been engaged with Minister Lebel federally and Minister Raitt to try and get the federal government to triangulate that into plans. Now many of you know that if it's Moosonee, it may be docks—there are all kinds of unique issues. So we're trying to move away from a cookie-cutter system, recognizing the diversity of Ontario communities.

I have a whole bunch of notes on transit which I won't bore you with because I gave you a fairly high level of that. I think you're all familiar with half-hour two-way GO service; all of the BRT systems: Viva, Züm and Mississauga. The Durham Pulse is one we're looking at extending right now. It connects Oshawa and the eastern GTA to U of T's Scarborough campus where most of their students come from. Centennial College draws most of its students from the eastern GTA and not downtown. So we're looking at a lot of institutional connections through BRT separate road systems in that system.

There are 9.7 million car trips taken in the GTHA each day, and that is huge. We know a lot of those could be transit rides because they're people going to a single destination. So we're doing a lot of mapping right now about where people live and where they go to work. We're particularly interested in those who do a single trip because if you're a salesperson going 15 places in a day, or you're a mom or a dad with a minivan and six or seven kids and ballet lessons and hockey lessons, those kinds of things are hard to manage, but we want to look at actually distinguishing which are the transit users.

But in rural Ontario, 70% of the trips are less than five kilometres. In urban Ontario, it's 50%. So the cycling strategy, #CycleON, which has been worked on with the Ontario Trucking Association, all of the cycling groups, the cycling union, as well as the CAA—we've had groups from Essex county to Thunder Bay to Ottawa to the Niagara region to eastern Ontario that have been participating in this. One of the things that's come out of it, the most cost-effective, healthiest way to get people moving is to get them on their bikes or walking. Literally half or up to 70% of those trips can be doing it.

We're noticing that one of the biggest interfaces in suburban Ottawa and suburban Toronto is people going from GO Transit, or from high-order rapid transit, on to their bicycles because the cul-de-sacs and winding streets of suburbs don't lend themselves to transit. Cars are expensive and hard to park, but for almost three seasons now we're seeing higher transit ridership. We also know that physical activity—half an hour to 45 minutes is one of the best takes on two huge problems we have, which is obesity and diabetes. I think in the next seven to 10 years we're looking at another million Ontarians with diabetes, and what that's going to cost us is huge.

So a lot of the transportation mandate has been divided up amongst other ministries. I know you had Minister Matthews here up until I came, but, for example, for the cycling strategy, health has one of the major responsibilities of it. We've actually suggested that doctors start writing prescriptions for cycling rather than for medication because simply riding to work today, back and forth, if you've got a two-, three- or four-kilometre ride is great.

1750

I'm on a weight-loss program right now; I've just lost about 30 pounds, and it's mostly from riding my bike and just giving up mechanical transportation. That's probably better than any diabetes drug or anything else that I was looking at if I didn't do that. It's a fun way to do it. We're trying to look at a more integrated approach if you want to reduce GHG emissions—active transportation. Again, we need new solutions.

As we look to the north, there have been a lot of discussions going on with members of all parties in northern Ontario—and all three parties have representatives—about the idea of: How do we look at coach service and transit service between communities? How do we protect and maintain routes? Elliot Lake, for example, right now is doing some very innovative stuff with not having to bring the big coach buses off the big highway into Elliot Lake, but providing better service by supporting an integrated service with the local regional service in smaller vehicles.

Moving to a transportation plan for the province, which is a priority for us, and a multi-modal plan, really looks at trying to work with local communities to integrate local solutions into province-wide areas. As the ONTC looks at a different future—and we look at GO—there has been, I think, a very dynamic conversation going on about: Can there actually be a big win here for a hybrid of public and private service delivery?

Multi-modal transportation is a huge issue. Safety is a greater concern, for myself and for Minister Ashton in Manitoba and Minister Gaudreault in Quebec. We have been working together, pressing the federal government right now to have a more comprehensive strategy, to actually look at the movement of all goods, not just by marine, truck or train but also pipeline, and to actually start to develop criteria for the most cost-effective and the safest way to move goods.

Whether pipelines are private or public, we have to actually start thinking about them as an integrated transportation system and to bring, after what happened in Mégantic, a much higher, more stringent strategy and standard to public safety and the movements of goods and services. I'm hoping that all parties in this Legislature, having seen what has happened in Quebec recently, will endorse, support and provide leadership in working to try and get safety standards up as we see a higher reliance on pipelines and also more train traffic coming in.

We're looking at trying to look at our marine assets and moving marine in more ways. As my friend David Crombie always used to say, "Everything is connected to everything else." We do have challenges with dropping lake levels. We're having troubles in the north with environmental concerns around winter roads and climate change. We have to be very proactive and on the leading edge of anticipating these kinds of changes that some of those communities are going to find alternatives to winter roads, whether it's fly-in communities or whether it's actually looking at new technologies and new types of infrastructure materials to build roads in the north.

Part of the challenge is that, while we've seen a major increase in funding of northern highways and of highways generally, to build a kilometre of highway in northern Ontario, where 90% of our geography is, costs us five times as much than to build a kilometre of highway in southern Ontario. So one of the things we are looking at with Canmet—and we're really trying to drive greater innovation so we can find more affordable ways to do that and more affordable ways to build bridges and to maybe mass-produce bridges. We have about 75 bridges or more right now that we're going to have to build. So we're looking at new materials. Rather than building them as one-off, can we innovate in different ways?

John Lieou, who is our ADM, has been doing a lot of work in open data and metrics. We want to be the first ministry in government to go to totally open-source government, where we would put all of the data that we collect—as you may know, the driver's licences and our road-user safety databases are the largest in government. Without interfering with people's privacy, we would really like to get all that data out there so people could actually look at and understand, along a potential highway route or in route selection, what the optimal benefits would be to an agricultural community for the movement of agricultural produce or stock. When we're talking about an urban environment—much richer data on land

use intensity, potential impacts and higher levels of investment in jobs and intensification resulting from transit better understanding the difference on intensification of an LRT line or a subway line.

Australia has done some of this work, but right now some of the most groundbreaking work is being done by Infrastructure Ontario and by the Ministry of Transportation and by some of the not-for-profits, like CivicAction, the Cities Centre at U of T and the Canadian Urban Institute.

We're actually looking at trying to do that as a partnership. We think that will create greater accountability in government, because people will understand the rationale on why a road or a transit corridor is built in one place, what land use policy may be in another or why one route would be expected. It will also help us attract more private capital for opportunities for private investments along those kinds of lines.

If you want to understand the problem, I always suggest you can understand it quite simply as, go to the top of the CN Tower and look north. You're looking at three major subway lines all built mostly over 50 years ago. The only one you can find is the Yonge line because it's the only one you'll see spiking around subway stations. The Bloor line has seen almost no intensification, and the Yonge-Spadina line has not seen any intensification. If you look at the ridership numbers, the Yonge line carries 42,000 people per hour; the others are often running empty for parts of the day.

So we have to look at criticality. Obviously, the downtown relief line has emerged as a major priority, as have some of the others. As we go to a more evidence-based process, we'll see better data to actually help select and prioritize. Metrolinx is playing a major leading role, with the TTC, for the first time to actually do a fully integrated land use and transportation system so all members of the Legislature and the public will understand what the implications of different choices are.

Also, connecting different modes of transit—I don't want to spend too much time talking about Toronto, but the Highway 427 extension into the CP Vaughan terminal is really important. One of the things that we're seeing is increasing concentrations of employment in places like Markham, Mississauga and downtown Toronto and more of logistics and bottling plants, warehousing and that kind of thing moving out more peripherally to the warehouses, which really affects our highway development. And working in our multi-modal and good services model, which we'll be releasing in the new year, is a more integrated approach to rail and road—and trying to shift more of the inter-regional transportation needs being carried by that.

Also, HOV lanes, we have moved onto highways like 403 and 404—they're being used widely in eastern Ontario as well, particularly in the Ottawa Valley. We think they're very positive, and they're actually creating more incentives for multi-occupant vehicles.

Border crossings are particularly critical. The Windsor-Essex Parkway will create one of the most important border connections ever. It's one of our biggest projects. We also know that by advancing that project as a provincial government, those of us in the Legislature really created the context which I think led to the United States agreeing to the construction of the presidential bridge. That is going to be one of the most important pieces of infrastructure all the way up the valley, from Windsor all the way up to Cornwall and beyond into Quebec. It simply takes the busiest border crossing between Canada and the United States and improves it to a quality that is extraordinary.

When I was talking earlier about northern highways, about getting our highway system up to the same standard of the Interstate so that we're not using it as it has become in some suburban communities—not a throughway but a go-to way, where it's being used more for big box retail than it is for moving important commercial and community traffic in and out, and protecting and restricting access. I think a very important conversation for the Legislature, going forward, will be the hierarchy of our highways. What are our truly national highways and regional highways? How do we protect them? Which highways should have commercial development on them? How do we manage access to our highways? I'm looking forward to a thoughtful discussion, because that's not just an urban issue. If you're on Highway 6 or Highway 7 or the double-digit highways, these issues of access, commercial use and through-traffic flow are critically important.

How am I doing for time?

The Chair (Mr. Michael Prue): We have about three minutes.

Hon. Glen R. Murray: Okay, so it's a good time to wrap up. Thank you very much.

I just want to touch briefly on road safety. Mr. Chair, as you know, with our community partners, governments present and past have worked very, very hard. Our drunk driving statistics are down significantly from last year. We are now at 50% below the national average. Distracted driving is an issue that I know many of us in a number of parties, certainly, a couple of the members of the official opposition—I particularly want to thank Jeff Yurek—have brought forward this idea. As our drunk driving rates are coming down dramatically, distracted driving accidents are going up very significantly, so I'm hoping that is something again—there are always advantages to a minority government—that finds favour in all three parties. I'm hoping that we can work together in a non-partisan way to put the people's business first and have the same success that we've had over decades of working to have the best drunk driving laws and the most successful education programs.

I know that a lot of you met with CAA today and Mothers Against Drunk Driving. We have an incredible civil society capacity. We have very strong laws on drinking and driving in this province. I would like to move to strong laws on distracted driving, but I'd like to say that it's the civil society, not-for-profit sector here that has really done yeoman service in getting out there and doing that, whether it's cycling safety, distracted

driving or drunken—I think we have to not keep our heads in the middle of government; we have to look to community and to citizens as partners in that.

We do have the safest roads in North America, which is quite remarkable, Mr. Chair, given the vastness of our land and the inordinately bizarre weather that we can have. That we have better and safer roads than Kansas or Iowa is quite remarkable.

We're up to 400% of what our traditional investment is in trying ways, without putting unnecessary pressure on hard-working families, to sustain that level of investment. I look forward to a robust and thoughtful conversation with the committee and thank all of you for your many hours of work. One of the hardest jobs in politics for MPPs is to do this kind of committee work, and I want to thank all of you for the time you put in. It's sometimes thankless, but this is a very important part of the business we do. Thank you, Mr. Chair.

The Chair (Mr. Michael Prue): I need to be sure. Would this conclude your remarks? We have to stop at 6, but you have about one minute left if you want to come back next time.

Hon. Glen R. Murray: No, I'll cede the one minute to the Chair for best wishes.

The Chair (Mr. Michael Prue): All right. Before adjourning, we will be back tomorrow at approximately 3:45. We will start with the half-hour for the Conservatives, just so everybody knows where we're at. We stand adjourned.

The committee adjourned at 1801.

CONTENTS

Tuesday 5 November 2013