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**Assemblée législative  
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**Official Report  
of Debates  
(Hansard)**

**Tuesday 29 October 2013**

**Journal  
des débats  
(Hansard)**

**Mardi 29 octobre 2013**

**Standing Committee on  
Estimates**

Ministry of Health  
and Long-Term Care

**Comité permanent des  
budgets des dépenses**

Ministère de la Santé  
et des Soins de longue durée

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## LEGISLATIVE ASSEMBLY OF ONTARIO

## ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON  
ESTIMATESCOMITÉ PERMANENT DES  
BUDGETS DES DÉPENSES

Tuesday 29 October 2013

Mardi 29 octobre 2013

*The committee met at 0902 in room 151.*

MINISTRY OF HEALTH  
AND LONG-TERM CARE

**The Chair (Mr. Michael Prue):** I call the meeting to order. We are here today for the consideration of the estimates of the Ministry of Health and Long-Term Care 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? We're all old hands at this. Okay.

*Interjection.*

**The Chair (Mr. Michael Prue):** Sorry. I'm being advised to wait in case the order is changed. If it is an order involving the minister, we have to go on to transportation or something else.

*Interjection.*

**The Chair (Mr. Michael Prue):** No, we can't. We can't even do it. I'll continue, and then if we need to—

*Interjections.*

**The Chair (Mr. Michael Prue):** I'll continue. I am now required to call vote 1401, 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.

But before I give over the floor to you, we'll just make sure that they're not changing the order. G105, okay. So we don't have to worry.

Madam Minister, the floor is yours.

**Hon. Deborah Matthews:** Thank you, Chair. Members of the committee, members of the public, thank you for the opportunity to speak here today.

For the fifth year, it is my pleasure to appear before this committee as Minister of Health, a role in which I have the privilege of working to improve the health of Ontarians and to safeguard and strengthen the province's cherished health care system.

Last year, I spoke to you about six months after I launched our government's action plan for health care. Our action plan started a major system transformation, and as a result, our health care system is going through one of the most significant periods of change since the introduction of medicare.

The action plan set out to tackle a twin challenge: the fiscal challenge and the demographic challenge. Health care spending in Ontario, as in other jurisdictions in Canada and around the world, was growing at an unsustainable rate. At the same time, we need to contend with a demographic shift as our population grows and our population ages.

If we don't change how we care for our seniors, health care spending will increase by 50% in the next 20 years, and that is before inflation. In particular, people with multiple, complex health problems require a disproportionate percentage of our health care resources.

We are very fortunate to have first-rate doctors, nurses and other health care professionals working here in Toronto. They are doing their part. But our system can be too hard for patients to navigate.

Ontario families want to know that there is a plan in place to ensure their parents and their grandparents, their kids and their grandkids get the care they need. At the same time, they want to know that they are getting best value for their tax dollars. That's why I've been absolutely determined to make the changes necessary to ensure that Ontario families have a world-class health care system they can rely on, today and tomorrow.

Today, more than 18 months after the launch of our action plan, I am pleased to say that the transformation of our health care system is in motion. Our initiatives are gaining momentum, and we will continue to build on them as we go forward. The entire health care sector is stepping up to the challenge, and we are seeing the results that are achieved when we work in partnership together.

The transformation taking place in Ontario has clear fiscal targets. Under the previous government, the health care system experienced deep, across-the-board cuts. When our government took office, we invested heavily—and strategically—to rebuild the health care system.

When the economy was strong, funding for health care grew at an average of 6% to 7% annually under our government. But with slower economic growth and our deficit reduction goal firmly in sight, that level of growth

is simply not sustainable. The results are in. Last year, we bent the cost curve and are holding the line to about 2% annual growth. I am equally determined to sustain this momentum going forward by keeping health spending growth at 2% this year and each year thereafter for the foreseeable future. To put this challenge in context, a 1% increase in the health budget is equivalent to the budget of nine other ministries, so achieving this goal means getting full value for every dollar we invest in health care.

We're equally determined to protect the gains we've made in health care since 2003. We have achieved this terrific result through strong action in a number of areas. The first one I'd like to talk about is drug system reform. Starting in 2006, our government has been implementing major reforms to the province's prescription drug system. We have:

- lowered the cost of generic drugs by 50%, to 25% of the cost of the original brand name drug for Ontario's public drug system;
- eliminated professional allowances to make Ontario's drug system more accountable;
- ensured that pharmacists are fairly compensated for helping patients by increasing dispensing fees and paying for additional pharmacy professional services provided to patients; and
- supported access to pharmacy services in rural communities and underserved areas with new dedicated funding.

In April 2012, we further reduced the cost of the top-selling generic drugs by an additional 5%. Our drug reforms have produced savings of about \$750 million in 2012-13 for the ministry's drug programs, savings that we were able to reinvest elsewhere in the health care system. Overall average spending increases on drugs is being held below 2% each year.

I'm also pleased to say that with Ontario taking the lead, most provinces and territories are moving toward a pan-Canadian price-setting initiative. Participating provinces and territories have agreed to establish a price point for six of the most common generic drugs at 18% of the equivalent brand name drug. These drugs represent approximately 20% of the publicly funded spending on generic drugs in Canada.

We're also working with the provinces and territories to negotiate listing agreements to support the reimbursement of new products under the public drug programs. This work has been led by Ontario and Nova Scotia. As of September 1 this year, we have completed 18 agreements, and negotiations are under way on 15 more. When fully implemented, this initiative could produce savings of up to \$100 million for provincial and territorial drug plans.

Now turning to the OMA agreement: When I appeared before you last July, we were in the process of restarting negotiations with the Ontario Medical Association. Since then, we reached an agreement that was ratified with the support of 81% of Ontario's doctors. The negotiations

were tough, but now physicians are true partners in helping us to transform health care.

The 2012 physician services agreement is designed to improve patient care, achieve better value for our health care dollars and allow Ontario to make new health care investments where they are needed most: in home care for over 100,000 more seniors. Under the OMA agreement, patients will benefit from 1,100 new doctors, with more options for access to virtual care, increased access to primary care for high-needs patients, and 30,000 more house calls this year.

Together, our government and the OMA have identified additional net savings of approximately \$400 million over two years, all of that reinvested to offset forecasted growth in physician services from an aging population and new doctors entering the system.

#### 0910

The agreement makes important evidence-based changes to doctors' fees so that we're paying the right amount for physician services and so that we're sharing the productivity gains that come from new medical technologies with patients.

We're partnering with doctors in physician-influenced system reforms. Importantly, the 2012 physician services agreement holds the OHIP physician services budget at \$11.1 billion annually until March 2014. Going forward, the 2014 physician services agreement negotiations present an opportunity to work with physicians on a joint vision for the future and the right incentives for the best care.

I want to speak about funding reform. One of the most important ways we're bending the cost curve is through health system funding reform, affectionately known as HSFR. With HSFR, we are ensuring that our hospitals' budgets are based on the characteristics of the population they serve, how many patients they see, the services they deliver and the quality of care provided. This means hospitals are becoming more accountable for the funding they receive and the services they deliver.

Going forward, funding is determined in two ways: first, through the health-based allocation model, known as HBAM, based on the health care needs and demographic characteristics of the local population; and secondly, through quality-based procedures where targeted health services are funded on a price-times-volume basis.

Funding for quality-based procedures, or QBPs, is based on evidence and encourages value for money, improved patient outcomes and consistently high-quality care across providers. In 2012-13, we set price- and evidence-based care pathways on four QBPs: hip replacement, knee replacement, chronic kidney disease and cataract surgery. Moving forward with year 2 of funding reform, we're adding six additional treatments to the list of QBPs this year, including stroke, congestive heart failure and systemic chemotherapy. This is a major change for Ontario's health care organizations. That's why we're working closely with them to ensure that we continue to

move forward at a brisk but manageable pace to get this done.

I want to take this opportunity to thank our health care leaders for their leadership in working with us to make this transformation possible.

I want to be clear that our small rural hospitals face different challenges. That's why they're not subject to health system funding reform. In the last budget, the small hospital sector received a 1% funding increase to recognize their unique needs. We also annualized our \$20-million transformation fund for small and rural hospitals to help them improve care.

Now let's turn our attention to the demographic challenge that we're addressing with health system transformation. The first aspect of that are new investments in home and community care. To help care for our aging population, our government has committed to increased community health care investments. The home and community care sector is a key enabler of the action plan. Care at home and in the community is more affordable than care in hospitals or long-term-care homes, and it is, without question, where people want to stay for as long as possible. That's why our 2013 budget earmarked an additional investment in the home and community care sector of \$260 million in 2013-14. That's a 6% increase this year, building on a 4% increase from the year before, and it means that over the past two years, we've created 76,000 more home care spaces, with another 30,000 more in the pipeline for next year. To care for more people at home, an additional three million personal support worker hours are being provided over the same period.

Part of this year's budget investment will help reduce wait times for patients who require nursing services and those with complex needs requiring personal support services. The target is to provide services to these individuals within five days of a CCAC assessment.

Again, I want to commend our partners in the home care sector for their work towards achieving this target.

We remain firmly committed to our Home First philosophy, which puts the right supports in place to help our seniors get home after they've been hospitalized. This has resulted in a significant reduction in ALC days, alternate-level-of-care days, in our hospitals. That's 25% province-wide—a 25% reduction in ALC days. It's also resulting in shorter waits for long-term care because people are getting the support they need at home.

Long-term-care homes should be reserved for those who really need the level of care provided there. That's why we've announced 250 additional short-stay beds in long-term-care homes across the province to help up to 1,500 more seniors get out of hospital sooner so they can move back home. Those of you who met with the Ontario Long Term Care Association yesterday heard about the success of that investment.

I want to mention the role of the Ontario Telemedicine Network. They're implementing Telehomecare in several LHINs, which makes it easier for seniors with complex conditions to manage their care at home. Over the past year alone, there has been a 50% increase in the number

of patients using telemedicine, providing better, more convenient care closer to home at a lower cost.

We know that seniors would rather age and receive care at home, close to their families and their friends—and, I'm learning, their pets—with the right supports in place.

Our Seniors Strategy: Healthy aging is all the more important when you consider that over the next 20 years, the population of seniors 65 and over will more than double from 1.9 million today to 4.2 million in 2036. Today in Ontario, about 14.6% of the population is 65 and over, yet we spend nearly half our health care budget on their care.

We're very fortunate to live in a time and place where citizens are living longer than ever. However, these greater life expectancies also mean our chances of living with chronic illness or disability have increased, putting additional pressure on our health care system.

So reform cannot wait. We need to take steps today to ensure the sustainability of health care, social programs and community supports that we need.

That's what led to the development of our Seniors Strategy and the appointment of Dr. Samir Sinha as our executive lead. During his widespread consultations, Dr. Sinha and his team quickly discovered that the concerns of older Ontarians are far-reaching. They cover health care, but they also cover social services, housing, transportation and community services.

Dr. Sinha's report is really about the social determinants of health that support healthy aging. It's about the physical, emotional, intellectual, spiritual, social and environmental wellness of older Ontarians. That means keeping seniors healthy is not only my ministry's job, but it's the job of all ministries and all sectors.

However, many of his recommendations were directly related to health care. The report recommends that we do more to support unpaid caregivers, especially when their tremendous support and dedication allows so many older Ontarians to live at home as long as possible. That's why our government remains committed to family caregiver leave.

Another recommendation underscores the importance of strengthening access to primary care to improve the health of older Ontarians. As a result, our government has committed to ensuring that every older Ontarian who wants one has access to a primary care provider.

We also responded to Dr. Sinha's recommendations by expanding access to physiotherapy, exercise and falls prevention programs for seniors and eligible community patients across Ontario. We want to keep seniors as healthy as possible, and in the community and at home as long as possible. That's why, in April, we announced that Ontario will expand access for an additional 200,000 seniors and patients to high-quality physiotherapy, exercise and falls prevention programs.

Before our changes, many people in this province had no access to this care in their communities. Furthermore, in recent years, billings for physiotherapy increased by 18% to 20% annually—the fastest-growing expenditure

in all of health care—but gaps in physiotherapy care across Ontario continued to persist.

#### 0920

For instance, there were only two physiotherapy clinics designated to provide government services—only two—in northern Ontario. Both were in Sault Ste. Marie. So that meant people in Sudbury, for example, might be eligible, but there was no clinic where they could receive care. That's not okay, so we fixed that problem. People in the north had to either travel to the Sault or pay out of pocket for those services.

Most of the increase in billings—that 18% to 20% annual increase that I'm talking about—was the result of exercise classes being billed to OHIP as if it were physiotherapy. Through audits, we've recently been made aware of the depth of inappropriate OHIP billings, which is why we put an end to this practice.

Under the new system, the number of publicly funded physiotherapy clinics is doubling across the province, and 12 of our 14 LHINs have cleared the wait-lists for in-home physiotherapy. Exercise and falls prevention classes are being offered in more locations, including long-term-care homes, retirement homes and in communities across Ontario.

Many seniors have come to rely on the services they received under the old model. The good news is, they will continue to receive the care they need, whether it's physiotherapy, exercise or falls prevention.

Eligibility for publicly funded physiotherapy is not changing. Long-term-care residents and patients in the community will receive the number of physiotherapy treatments they require in order to recover from their injury, their illness or their surgery, either at home or in community clinics. We're very pleased that these reforms are supported by the Ontario Physiotherapy Association, the College of Physiotherapists of Ontario, the Canadian Physiotherapy Association and the Ontario Home Care Association.

It's clear that a lot of work has been done to transform health care. Now we need to sustain the momentum we've created.

I was encouraged by a recent Conference Board of Canada report, which gives Ontario's health care system an A across 90 indicators in four categories. What struck me most about the findings was that spending more health care dollars does not necessarily translate into better performance.

The report confirms what we've known for some time: The problem isn't that we're not spending enough; the problem is that we're spending some of it on the wrong things. We need to maximize health care investments by shifting a number of services into more appropriate and cost-effective settings, ensuring that the services are provided at the right time and in the right place, while meeting the highest-quality standards of care. That's why, this year, we will look to move appropriate procedures out of acute care settings and into the community.

We started with the establishment of two community-based birth centres, one in Toronto and one in Ottawa, to

provide women with more choice on where to have their babies. The two centres are expected to assist with a total of 900 to 1,000 births annually.

Last fall, we further expanded services at the Kensington Eye Institute, where approximately 300 cornea transplants are now taking place over the course of a year. Waiting lists are already improving.

We need to keep the momentum going. So, over the course of 2013 and 2014, we're planning calls for proposals to establish non-profit specialty clinics focused on other routine procedures, including colonoscopies, dialysis, hip and knee surgeries and MRIs. These services would be funded just like the quality-based procedures in our hospitals.

Offering these services in the community means that patients can get care closer to home, with an improved patient experience. This shift will allow our hospitals to focus their efforts more on acute care.

I want now to talk about hospital infrastructure. Since 2005, we've invested more than \$14 billion in health care infrastructure. We've built the following new or expanded hospitals: William Osler in Brampton Civic Hospital; the Royal Ottawa Health Care Group; the West Parry Sound Health Centre; Peterborough Regional Health Centre; Thunder Bay Regional Health Sciences Centre; Mattawa General Hospital; Runnymede Healthcare Centre; Bloorview Kids Rehab; L'Hôpital régional de Sudbury Regional Hospital; Pembroke Regional Hospital; Sioux Lookout Meno Ya Win Health Centre; Sault Area Hospital; North Bay Regional Health Centre; Woodstock General Hospital; Sarnia's Bluewater; Niagara Health System at St. Catharines; and Bridgepoint Health. And the following projects are under construction: St. Joseph's Health Care London; St. Joseph's Healthcare Hamilton; Cornwall Community Hospital; Halton Healthcare Services; Humber River Regional Hospital; and Women's College Hospital. In total, 23 hospitals right across this province have either been built or are under construction. In addition, there are over 100 major capital projects.

Long-term-care homes also have an important role to play. That's why we are redeveloping 35,000 long-term-care beds, to ensure modern homes are available to our long-term-care residents. Since 2003, over 11,000 long-term-care beds have been redeveloped and more than 9,000 new beds have been built.

If we're going to improve care and get better value for our health care investments, we must have a laser-like focus on those who need health care the most. Research shows that one third of the health care budget is spent on just 1% of Ontarians, while 5% of patients account for two thirds of our health care budget. Many of these patients are seniors with complex, multiple needs, people with mental health issues or those with chronic conditions. Seventy-five per cent of seniors with complex needs who are discharged from hospital receive care from six or more physicians—six or more physicians in addition to home care, community services, pharmacists and a range of other health providers.

Frequently, the care seniors receive from all these providers is not coordinated, and that can lead to duplication, poor patient care and higher costs to the health care system. All too often, gaps in care can result in preventable trips to the emergency department. Even a 10% reduction in the cost of care for those Ontarians would save about \$2 billion, funds that could be reinvested in the system.

That's why we're focusing our efforts on these high-needs patients through the establishment of community health links. Health links have had a remarkable start, and are truly a health care movement from the ground up. Health links bring together all of the health care providers in a given geographical area with one goal in mind: coordinating care for the highest-needs patients. That means patients, family members, family doctors, specialists, home care nurses, hospitals, community health services, pharmacists and others are all at the same table, with the same goal, and that is to provide the best-quality, highly coordinated care, with the patient at the centre.

When I announced Health Links last December, there were 19 early adopters, 19 communities who wanted to be there right from the beginning. We're now up to 37, and more will be added across Ontario. We look to the day when all of Ontario will have a health link.

Health links build collaboration among health care providers. By coordinating care, they truly do put the patients at the centre. Each patient will have an individualized, personalized care plan developed by providers and the patient, who plays a central role in creating the plan so that it focuses on what is really important to that individual.

With improved coordination and system information-sharing, patients will receive faster care and spend less time waiting for services, and with their family health care provider at the heart of their care plan, we're fulfilling our action plan promise to provide faster access and a stronger link to family health care. Health links tap into the motivation of providers to do a better job for their patients. They chose health care as a career to make a real difference in patients' lives.

Our government will play its part too. My ministry will be there to provide advice and guidance, share best practices among health links and, more importantly, remove barriers and drive innovation across the province. I look forward to sharing more of the success stories coming from this exciting development over the coming year.

**0930**

The action plan's goal of providing the right care at the right time in the right place requires that all our health care professionals work to their full scope of practice. This especially applies to nurses, nurse practitioners, dietitians, pharmacists and midwives. We've expanded pharmacists' scope of practice even further to provide more services to patients and improve their access to care.

Starting last fall, Ontarians five years of age and older can go to participating local pharmacies where specially trained pharmacists give them their flu shot. That connection to pharmacies in communities across Ontario has helped to ensure continuity of care.

**The Chair (Mr. Michael Prue):** If I can just break in, you have two minutes.

**Hon. Deborah Matthews:** I have so much more to share.

**The Chair (Mr. Michael Prue):** I know, but there is an option, if the committee agrees, to allow you to finish and take that off the back end. I know that there's more.

**Hon. Deborah Matthews:** Sure.

**The Chair (Mr. Michael Prue):** Would that be acceptable?

**Mr. Rob Leone:** That's their back end.

**The Chair (Mr. Michael Prue):** It's theirs. It would come off the minister's turn. The minister has another half—okay.

**Hon. Deborah Matthews:** Okay, then I'll carry on.

**The Chair (Mr. Michael Prue):** Then carry on and finish, and we'll take that time off the end. Okay.

**Hon. Deborah Matthews:** Thank you. So last year's integration of pharmacies into the Universal Influenza Immunization Program was very successful. Pharmacists administered about a quarter of a million flu shots in local pharmacies. More and more pharmacists are being trained to administer injections. This flu season, we expect 2,000 pharmacies will now offer the flu shot—triple the number of last year.

The flu shot is one of a number of new services that pharmacists can now provide. Premier Wynne also committed to expand the scope of practice for registered nurses and registered practical nurses so they can dispense medication in specific circumstances.

Regulated health professionals, like nurse practitioners, nurses and dietitians, are working hard as members of health care teams across the province to reduce wait times and improve access to care in hospitals, community health centres, long-term-care homes and family health teams. And our dedicated midwives have helped bring 22,000 new Ontarians into the world—one of them my granddaughter—up significantly from 8,000 births just a few years ago.

And here's another fact: In 2003, Ontario screened for only two genetic diseases. Now we screen—newborn screening—for 29, saving the lives of an estimated 1,000 babies at no cost to parents. We're now in discussions with our provincial counterparts on how to increase newborn screening nationwide.

Overall, access to care has improved for patients, thanks to 200 family health teams, 25 nurse-practitioner-led clinics and 76 new community health centres. The vast majority of Ontarians—93%—now have access to a family doctor. If you're a person with diabetes, that number is 100%. And we're working, as I said, to provide a family doctor or a nurse practitioner to every senior who wants one.

Through our successful Wait Time Strategy, we've cut key surgical wait times in half. I'm very pleased to say that Ontario is once again the national leader in reducing wait times for five priority health services, according to a report card issued by the Wait Time Alliance. For the sixth consecutive year, the Wait Time Alliance gave Ontario straight As for meeting performance targets in reducing wait times for hip replacements, knee replacements, cataract surgery, radiation oncology and cardiac services.

The report also gave Ontario straight As for reducing wait times for non-admitted patients in hospital ERs—87% of ER patients are getting treatment within the eight-hour target for complex patients and four hours for less urgent patients. That means better care when people need it the most.

I'd like now to turn our attention to health promotion. The first pillar of our action plan is keeping Ontario healthy. It's part of our ultimate goal to make Ontario the healthiest place in North America to grow up and grow old.

We know that people want better health, not just more health care. Government can't do it alone, but we can help, and one of the ways is to continue the fight against smoking. Every year, tobacco-related disease costs the province an estimated \$1.9 billion in direct health care expenses.

We've already accomplished a great deal with Smoke-Free Ontario, and we renewed the strategy for a further five years.

As part of our plan to help smokers who want to quit, 45 community health centres across the province now provide over-the-counter nicotine cessation aids and counselling at no cost to smokers. As well, 11 community health centres are about to launch free nicotine replacement therapy. Currently, over 23,000 patients are enrolled in these programs.

Ontario has launched two more innovative smoking cessation initiatives, partnering with workplaces and 11 public health units to reduce smoking among workers in the industrial and service sectors and helping patients in hospitals and regional cancer centres quit smoking. These new initiatives build on the success of other supports we offer smokers in Ontario, including free nicotine replacement therapy at 128 family health teams across the province, and providing better access to smoking cessation medications, which can now be prescribed by pharmacists.

Another way we're safeguarding the health of our young people is by passing legislation that will prohibit the use of tanning beds by youth under 18 years of age. We are thankful that this life-saving bill is now passed into law.

Finally, we've received the report from the Healthy Kids Panel that provides us with invaluable advice on how to address childhood obesity and make our kids healthier. We've started to implement the panel's recommendations, beginning with new supports to help every mom in Ontario who wants to breastfeed her baby. Early

next year, we'll offer 24/7 Telehealth support to breastfeeding moms. We're working with our hospitals and community health care providers to attain designation under the World Health Organization's baby-friendly initiative, so that they are able to teach moms and their babies how to breastfeed.

As I announced recently, our government intends to introduce legislation this winter that would require large-chain restaurants to include calories on menus and menu boards, and we're consulting on how to restrict the marketing of unhealthy foods to children.

Underlying our transformational work is a deep commitment to improve the transparency and accountability of the entire system. We want to ensure that every care provider, administrator and agency understands that they have been entrusted with hard-working Ontarians' tax dollars, and they need to be accountable, not just to government, but to the people we serve.

Individuals and families now have much better tools to help them understand how their health care system works and how to navigate its complexities. For example, the results of long-term-care-home inspections are now available online to help families make an informed decision about where to place their loved ones.

Accountability and transparency are a priority for me, because they drive change. I'm pleased to say that we've already made substantial progress in transforming the province's health care system. We want to keep that momentum going and seize opportunities for transformation to get better care for patients and better value for taxpayers. The health system we want to achieve through the action plan is sustainable, is patient-centred, evidence-based and promotes quality, all while providing the care people need today and tomorrow.

Thank you for your attention, and I invite your questions.

**The Chair (Mr. Michael Prue):** Thank you very much. Just for the record, you used about seven minutes additional, so we'll take that off the next time.

The floor now goes to the official opposition. You have 30 minutes.

**Mr. Rob Leone:** Thank you, Chair, and thank you, Minister, for your elaborate discussion this morning on the state of health care in the province of Ontario.

I want to move to page 18 of your remarks, in particular the hospital infrastructure projects that you've listed here and enumerated since 2005. You list about 23 projects that either have been constructed or are in the process of being constructed. Now, I note that recently in question period, you had listed a number of hospital expansion projects that actually aren't included in this list. I'm wondering why the discrepancy with what you said in question period recently with what you have on this page.

**Hon. Deborah Matthews:** These are new hospitals. There are, in addition, as I said, 100 major expansion projects, so that could account for the discrepancy. Was there one hospital in particular you wanted to—



**Mr. Rob Leone:** Well, obviously, I was going to talk about Cambridge—

**Hon. Deborah Matthews:** As you know, Cambridge—

**Mr. Rob Leone:** —and Joe Brant, another one that I know you listed recently in the Legislature. But 18 through 23 here—“the following projects are under construction,” and you list St. Joseph’s Health Care in London, St. Joseph’s Healthcare in Hamilton, Cornwall Community Hospital, Halton Healthcare Services, Humber River Regional Hospital and Women’s College Hospital, and then you stop at that. I know that obviously Cambridge has been long seeking a hospital infrastructure project and that’s not listed in here. I’m wondering why.

0940

**Hon. Deborah Matthews:** Because it’s an expansion; it’s not a brand new hospital. If you would like, I could read into the record the hundred expansion projects.

**Mr. Rob Leone:** You stated here at the top of your list, “We have built the following new or expanded hospitals.”

**Hon. Deborah Matthews:** These are significant—

**Mr. Rob Leone:** I’m questioning where the list is derived from. I just don’t understand that.

**Mr. Joe Dickson:** I’d like the minister to read in the hundred.

**Mr. Rob Leone:** You can do that in your time.

**Hon. Deborah Matthews:** As I say, Cambridge, as you know, is going ahead. Cambridge is a major expansion. It is not a brand new hospital. I would be more than happy to read into the record the hundred expanded hospitals.

**Mr. Rob Leone:** I’m just wondering why it’s not on your list in your remarks. My question is that. Why isn’t it on this list? “And the following projects are under construction”—you’ve listed six hospitals, and Cambridge is not one of those, Joe Brant is not one of those.

**Hon. Deborah Matthews:** I will happily get you an answer as to where we draw the line between how big an expansion has to be before it makes it onto the list of 23, but you know that you’re getting a significant expansion in Cambridge. I think your constituents are very happy with that.

**Mr. Rob Leone:** In a follow-up to that—

*Interjection.*

**Mr. Rob Leone:** Thanks for speaking on my behalf, Mr. Dickson.

My second follow-up question to that: When will the money begin to flow for all these projects that you’ve—

**Hon. Deborah Matthews:** Well, many of these have already been built and opened. These are I think all AFP projects, I believe, alternative funding plan projects, so they have a 30—

**Mr. Rob Leone:** What does that mean?

**Hon. Deborah Matthews:** This is where they have a plan, design, construct and maintain—some of those components, or all of them. One consortium is selected to construct the project, and the maintenance of the building

is included in that price. The result is, the builders are very focused on building to the highest quality standards because they know, at the end of 30 years, they’re going to have to turn it over in excellent condition.

**Mr. Rob Leone:** So AFP is a nice, fancy word for public-private partnership?

**Hon. Deborah Matthews:** The distinction is that with an AFP model, at the end of the period, the hospital belongs to the people of the province. Under a P3 model, that’s not the case. It’s like paying a mortgage over time, but at the end of it, we own the asset.

**Mr. Rob Leone:** We had Finance Minister Sousa in estimates recently and I asked him the question I think a lot of Ontarians have, which is that there have been a lot of commitments made for infrastructure projects right across the province: health care, education, roads, infrastructure, public transit and the like. I asked the minister, where’s the money coming from? I’m going to ask you the same question: Where’s the money coming from?

**Hon. Deborah Matthews:** This is all included in our budget. We know that we will be paying for these projects over a number of years. I noted yesterday that you’re supporting the construction of a new hospital in Niagara Falls. I can only assume you would do it on an AFP model. I’m making that assumption. We’re getting these hospitals built now. People are benefitting from the efficiencies and the improvements in quality of care that can be provided in the new facilities. We will be paying for them over time and it’s all in our budget.

**Mr. Rob Leone:** In estimates, Finance Minister Sousa suggested—and I asked him repeatedly to clarify this question—that basically capital infrastructure projects are being added to the debt. There is no new money, per se, that’s being allocated to that. In addition to a \$10-billion deficit that this government is projecting—and we’ll get an update on November 7, I understand—another \$10 billion is being added to the debt, and that \$10 billion is simply as a result of infrastructure projects. Is that where the money to build hospital expansion projects is coming from?

**Hon. Deborah Matthews:** This is in our budget. The—

**Mr. Rob Leone:** So the answer is yes.

**Hon. Deborah Matthews:** These are government expenditures.

**Mr. Rob Leone:** So the answer is yes, it’s coming through debt.

**Hon. Deborah Matthews:** Well, I would quarrel with you on that. These are government expenditures. If you want to say that cancer care adds to our debt, yes, I guess you’re right. Providing care for people with cancer adds to our debt. That doesn’t mean we shouldn’t do it.

**Mr. Rob Leone:** Well, I’m not suggesting that. I just want a confirmation on capital infrastructure projects. The government really doesn’t have the money to pay for those upfront. You’re saying that by going through the AFP process, you’re extending this through the whole period of time.

**Hon. Deborah Matthews:** That’s absolutely right.

**Mr. Rob Leone:** Now, if we have an AFP for a hospital, where is the risk allocated? Is that on the government's books in terms of when they're paying, when they're enumerating their debt, or is that risk transferred to the private consortium that's building the project?

**Hon. Deborah Matthews:** I will ask the deputy—

**Mr. Rob Leone:** So is it included in the debt figure or is it not?

**Hon. Deborah Matthews:** I will have the deputy—

**Mr. Saäd Rafi:** I think I heard a couple of questions. One is, when does the payment start? The payment starts when the facility is deemed substantially complete, and since hospitals are consolidated onto the government's books, that consolidation begins at that time.

I'm sorry, I forgot the other part of your question.

**Mr. Rob Leone:** It was in response to the AFP model that you suggested. Is that on the consortium's books, or is that on the government's books when—

**Mr. Saäd Rafi:** Oh, risk transfer—I'm sorry, yes. So the transfer of risk is in the AFP model, and that risk transfer is, for example, an on-time, on-budget completion of the project. The payment for the project doesn't start until the project is deemed substantially completed. So if construction takes three years and the consortium is longer in completing that project, they don't start getting paid until the project is deemed—the term is “substantially complete”; in other words, complete and ready to move into.

**Mr. Rob Leone:** So if it's a \$300-million project, the \$300 million isn't going to appear as debt to the government. What the government is basically paying out is the instalment fee that they're going to pay to the consortium over a 30-year period?

**Mr. Saäd Rafi:** Yes, like a mortgage.

**Mr. Rob Leone:** Okay. Mr. Clark.

**Mr. Steve Clark:** I have two questions, Minister. I'm reading page 31 of your estimates, end-of-life and palliative—

**Hon. Deborah Matthews:** I apologize. I have a larger font on mine.

**Mr. Steve Clark:** End-of-life and palliative care.

**Hon. Deborah Matthews:** Yes.

**Mr. Steve Clark:** The second paragraph says, “As part of the ministry's 2005 end-of-life-care strategy, 34 residential hospices or communities were identified and CCACs were given funding to use on palliative and end-of-life care”—

**Hon. Deborah Matthews:** I'm sorry. What are you reading from?

**Mr. Steve Clark:** I'm reading from this document right here.

**Hon. Deborah Matthews:** Oh, I'm sorry. Okay.

**Mr. Steve Clark:** So I guess my question—I have a community in my riding, North Grenville, who have worked with the LHIN for the last many years actually, and I'm asking a question to be answered at a later time by the ministry. I'd like to get a sense of how that project works into your strategy and how this year's estimates

will deal with funding residential hospices in local communities.

I think our community has worked well with the LHIN. They're ready to go. I want them to move forward, and I'm just trying to figure out, based on what I'm reading, how our community works into that strategy. That's a bit of a fact-finding mission, because I think we're ready to move forward. I'd just like to put that on the record and ask that you address that.

**Hon. Deborah Matthews:** Thank you. I will happily do that. I will obviously look into that particular request, but there is no question in my mind that the hospices that are being built across this province are providing excellent care to people at the very end of their lives. And as we talk about how we are going to care for people at the end of their lives, many people will choose to die at home, with the right supports, others will die in hospital, but I think building that continuum of care so that people do have access to hospice care, if possible, and if there is community support, because we do rely heavily on communities to contribute to the cost both of building and of supporting that—

**Mr. Steve Clark:** Yes, and this particular hospice is very entrenched in the community. It's always provided volunteer residential hospice and now wants to move to the next level of providing that 10-bed model, and they've worked quite closely with Champlain.

**Hon. Deborah Matthews:** Perfect, okay.

**Mr. Steve Clark:** So, again, I think we're ready.

**Hon. Deborah Matthews:** Excellent.

**Mr. Steve Clark:** I just want to make sure that the minister and the ministry are ready.

**Hon. Deborah Matthews:** I will look into the status of that.

**Mr. Steve Clark:** Okay. The second issue, Chair, if I might, through you to the minister: I'm reading, again, page 27, “Community Mental Health and Addictions,” which is something that I'm extremely interested in. I read very carefully the words “The right care at the right time at the right place is critical in the area of mental health and addictions services.” I'm quoting page 27 of that same document.

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I'm trying to understand the relationship in my community to the Ministry of Health and the ministry of corrections. The example that I'll use is a male secure treatment unit that operates in our community, that works with both ministries. I know, with things like the Ashley Smith inquest that's taking place and some other announcements that are taking place—I just want to know who drives that in a correctional setting.

I agree that the right care at the right time at the right place is very critical. I'm just hoping that the Ministry of Health has some issue and some priority to making sure that happens, as opposed to corrections putting that treatment model in wherever you seem to have an opening. I'd love to hear your comments on that.

**Hon. Deborah Matthews:** We launched our Mental Health and Addictions Strategy, a 10-year strategy, about

three years ago. As you know, the three-party committee that looked at mental health and addictions did an outstanding job and issued a report back to us.

Years 1 through 3 of the strategy are focused on children and youth, because we know that 70% of mental illness actually starts in childhood and adolescence, so we're really focusing on expanding services there. But we are working to develop years 4 through 10, which will have a stronger focus on adults. That work is well under way now—

**Mr. Steve Clark:** Sure, but conceptually, if we agree that the right care at the right time at the right place is what we should focus on for children and adolescents, should we not also have that same strategy when your ministry works with corrections—

**Hon. Deborah Matthews:** Absolutely, yes

**Mr. Steve Clark:** —on trying to provide that in the setting?

**Hon. Deborah Matthews:** Absolutely.

**Mr. Steve Clark:** I'm worried, Minister, that corrections will be driving how treatment takes place. I personally think that we need to move people out of the corrections system and move them into a model like I have in my riding, in Brockville.

I'm worried that we're not putting enough emphasis on treatment of women in the correctional system. We have had some success with the male treatment unit. We've had people, some women, from some of our correctional facilities treated successfully through that model. But again, I happen to think that if we're going to have the right care at the right time at the right place, you have to have some authority over how treatment is given and how your relationship with corrections lays out where treatment ultimately rests.

Again, is that something that you believe you should have a priority over?

**Hon. Deborah Matthews:** You know what I'd like to do? I'd like to do a little homework to get exactly some clarity around who is responsible for providing care.

Obviously, if a psychiatrist is in a forensic mental health building, they are providing care and governed by the standards of the profession.

I'd like to know more about what actually it is you're asking. You're asking, does the Ministry of Health run those facilities? I'd like some clarity about what your question is. If you're saying we need to focus on that—

**Mr. Steve Clark:** Yes, I guess we have to treat people, right?

**Hon. Deborah Matthews:** Absolutely.

**Mr. Steve Clark:** And if we can treat people rather than having them in a correctional setting, I think that's a good thing. I think we've got cases and examples in the province of Ontario—we have some success stories. I know that in my own community, I look at some of the recidivism rates of people being treated. Certainly, the model that we have for males in Brockville at the secure treatment unit is very successful. I'm just worried that when it comes to issues around, for example, the Ashley Smith inquest and some of the ultimate recommenda-

tions, we're going to try to provide a model in whatever correctional facility is available.

I think, again, to use your words, the right care, the right time, the right place—I think that from a health care perspective, as the minister, you want to make sure that happens, and you should be able to step up and help guide, ultimately, where that treatment takes place. So I would—

**Hon. Deborah Matthews:** I'm very happy to know you have an interest in this—

**Mr. Steve Clark:** I'm glad you're happy.

**Hon. Deborah Matthews:** —so we can work together.

**Mr. Steve Clark:** I'm happy you're happy.

**Hon. Deborah Matthews:** Excellent.

**Mr. Steve Clark:** Okay. I think I'm okay with my questions.

**Mrs. Christine Elliott:** Good morning, Minister and Deputy Minister. I do have a number of questions, but I'd like to start with a few arising out of your remarks from this morning.

If I could turn to page 5, at the bottom of the page where you're speaking about pharmacists and expanding scopes of practice, I recall that when the changes were made to the generic drug pricing several years ago, there were commitments that were made by you that there would be a compensation to pharmacists by increasing the scope of practice. Right now, they're able to deliver flu shots, but I think that they were expecting far more than that. Can you tell me what you plan to substitute, or to allow them to do, to expand their scope of practice to compensate for that loss?

**Hon. Deborah Matthews:** We've been working very closely with the pharmacists to really transform that sector of the health care system from what they used to be able to do, which was simply dispense drugs, to proving much more care. We are compensating them for that; so we compensate for the flu shot.

I think, for me, the single most important expansion of their responsibilities is around MedsCheck. When people are discharged from hospital, people on multiple medications, pharmacists can review all of their medications. As you heard me say, for these complex patients with six or more physicians, each of them with the ability to prescribe and not necessarily coordinating that, a pharmacist can go in and review all of the medications and make sure the patient knows what they should be taking and when. We're even funding MedsCheck at home now, where pharmacists can go to someone's house and go through all of their medication, both prescription and over the counter, and make sure they're getting the right medications. So we're expanding that.

I talked about their doing smoking cessation programs. Pharmacies across the province now have built rooms where they can work with patients, whether it's on smoking cessation—they can prescribe smoking cessation products now—the flu shot, MedsCheck, a range of services they can provide.

We also, of course, increased the dispensing fees and we have a special bonus on dispensing fees in small communities, because we wanted those drugstores to be able to stay open, because they provide an important service for people.

So we're continuing to work with the pharmacists on what further expansion they're looking for. I know they're looking for the ability to treat common illnesses, and so—

**Mrs. Christine Elliott:** They're also looking for the ability to renew common prescriptions as well as doing other types of vaccinations and that sort of thing. Is that part of your immediate plan, to allow them to do that?

**Hon. Deborah Matthews:** We are definitely committed to continue to expand the scope of practice, not just for pharmacists but for others, but I think this provides real value for the people of the province. We're continuing to look at expanded scope for a range of providers.

**Mrs. Christine Elliott:** All right. Thank you.

My next question arises out of your comments on page 11, where you talk about: "The target is to provide services to ... individuals"—home care—"within five days of a CCAC assessment." Can you tell us what the progress is in that respect and where you are with that?

**Hon. Deborah Matthews:** Why don't I just share with you where we are on that?

Do you have that handy?

**Mr. Saäd Rafi:** I think so. On nursing days—these are all from first assessment of the individual—for nursing days it's all clients or all patients. The average wait time in the 90th percentile is four days currently, and the target was five.

On PSW, time waited for complex patients from first assessment, there is more work for us to do there. It varies, but the average 90th percentile wait time is 20 days, and the goal, which was announced in the 2013 budget, is to get to five days there as well. Clearly, that's going to take more time and there's an inordinate amount of funds assigned for PSW wait time than nursing wait time, as a result of the current wait.

**Mrs. Christine Elliott:** Okay, so can you tell us what the plan is, then, to deal with that, because that is a considerable wait time, 20 days for a—

**Mr. Saäd Rafi:** The LHINs have been allocated \$60 million for that specific wait time, plus there was an additional \$15 million allocated for nursing wait time; in addition to that, \$115 million for just a growth in home care. So each LHIN will have to look at their current wait times; some in PSWs are as low as seven, so they would have differential strategies to get from first assessment to first visit. That's in development right now. This was just announced at the end of April in the budget. We're working with them over the course of this fiscal year, and we'll also try to develop a reporting method with CCACs so that it's transparent to all Ontarians.

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**Mrs. Christine Elliott:** Is there a goal in terms of time to achieve that reduction from 20 to five days?

**Hon. Deborah Matthews:** I believe we think we can do it over the next two years.

**Mrs. Christine Elliott:** Two years.

**Hon. Deborah Matthews:** I'll correct this if I'm wrong.

**Mrs. Christine Elliott:** It's still a considerable amount of time, but—

**Hon. Deborah Matthews:** Yes, but we're really making progress. It's pretty fantastic when you look at how many more people are getting home care, and now we can focus on wait times. I think we've doubled spending almost on that home care sector because we believe that's where the need is, and that's where people want the care.

**Mrs. Christine Elliott:** We continue to hear about people being readmitted to hospital before they even get connected with home care, so that's certainly something that needs to be worked on.

**Hon. Deborah Matthews:** If I thought the problem was fixed, I would tell you that. I'm not telling you it's fixed. I'm saying we're absolutely focused on doing a lot better.

**Mrs. Christine Elliott:** Another question, again, on the bottom of page 11, top of page 12, talking about the long-term-care homes and wait-lists: You indicated that you've helped 1,500 more seniors get out of the hospital as soon as they could move back home. Can you tell us what the wait-list is now, the number of people waiting for long-term care?

**Hon. Deborah Matthews:** So the—

**Mrs. Christine Elliott:** And the wait time, as well.

**Hon. Deborah Matthews:** The wait time—let me see if I can pull that number up. I had it recently.

We are definitely seeing a decrease in the wait time as more people are getting care at home, which is terrific.

**Mr. Saäd Rafi:** On average, it's 50 days out of hospital and 90 days from admitting from community.

**Mrs. Christine Elliott:** And how—

**Mr. Saäd Rafi:** For first choice.

**Mrs. Christine Elliott:** Okay, and how many are on the list now?

**Hon. Deborah Matthews:** I'm not sure we actually have that number.

**Mr. Saäd Rafi:** The exact number, I don't have.

**Hon. Deborah Matthews:** But 50 days and 90 days, when people are actually making that move into long-term care, they need some time to make that move both psychologically and physically. So we're happy to see the wait time coming down.

**Mrs. Christine Elliott:** Could you undertake to provide me with the number of people who are still on the list?

**Hon. Deborah Matthews:** We will do our best.

**Mr. Saäd Rafi:** Yes.

**Mrs. Christine Elliott:** And what the numbers have been over the last 10 years, if we could get that, from 2003 to the present.

You also talk about the role of the Ontario Telemedicine Network, making it easier for seniors with

complex conditions to manage their care at home. Can you tell me what it is that they actually do and how much that costs?

**Hon. Deborah Matthews:** I'll preface this by saying the Ontario Telemedicine Network is a global leader in telemedicine. Ontario is leading the world when it comes to providing care for people using that technology.

Telehome care is another way we can employ technology to improve quality. I think there are a variety of applications of telehome care, including people having a device in their home where they can check in with the providers, tell them they're okay in the morning, let them know if they've taken their medication. I don't know if you have details there on what that technology actually looks like, but there are a range of models, I believe.

**Mr. Saäd Rafi:** That's right. We piloted this, in the first phase, in three LHINs where we're working with approximately 800 patients to assist with everything from reducing their readmissions to hospital—we experienced a 72% reduction in emergency department visits, a decrease in the number of primary care visits that they've undertaken and a dramatic reduction, about 95% to 97%, in their use of walk-in clinics. This is the first wave of a project that we hope to roll out across other LHINs.

On telemedicine, there are 1,600 video link sites across the province where one can go and have a consult with a physician, many times a specialist; 236,000 consultations were done through telemedicine. That's 114,000 unique patients, so some people had presented twice, obviously.

I can tell you what the avoidance cost is, at this point, anyhow, which was an estimated cost avoidance of \$44 million annually in just northern travel, which is where the concentration of these telemedicine sites is—in northern Ontario, of course.

**Mrs. Christine Elliott:** Thank you.

**Hon. Deborah Matthews:** And if I could just add, one of the investments that was made through the \$20 million allocated for rural health transformation—I actually visited the hospital in Perth county, and they are doing addictions and mental health through telemedicine. So they actually set up a unit in the person's home, and they check in via telemedicine with their counsellors, saving them a very long trip into the clinic. So there are many, many applications for this. We're just starting to see how remarkable the opportunity is.

**Mrs. Christine Elliott:** But this project for seniors is a new one that's just being piloted in three LHINs. Am I correct?

**Mr. Saäd Rafi:** It's for all manner of patients, not just seniors, and it's being piloted in three LHINs—the first wave of it, yes.

**Mrs. Christine Elliott:** Okay. Can you tell me the cost of the pilot project and then the anticipated cost if the pilot is successful, what that would be?

**Mr. Saäd Rafi:** I will get that for you. I don't have it at my fingertips. Sorry.

**Mrs. Christine Elliott:** All right. Thank you.

**Hon. Deborah Matthews:** But I think it's very clear that the cost avoidance will far outweigh any costs. It will reduce walk-in visits by 97%, ER admissions—stunning results.

**Mrs. Christine Elliott:** We'll look forward to seeing that as that rolls out.

The next question arises out of page 14, speaking about physiotherapy. Certainly what we've heard from a number of both individuals and long-term-care homes is that they're very concerned about the cuts to physiotherapy that they have seen, that they are not seeing expanded access; they are actually seeing cuts.

I was just speaking with people at the function last night, the Ontario Long Term Care Association, that there are a number of individuals who are concerned about their parents' health, that they're saying their health declined, that they're not getting as much access to physiotherapy as they did several months ago.

Similarly, some of the long-term-care facilities have expressed concern about the additional costs that they will be incurring as seniors become less mobile and the number of additional staff that they're going to be requiring to help more people in walkers, more people in wheelchairs.

I'm wondering, when you brought in this regime, did you consider the additional costs that would be incurred as a result of these changes?

**Hon. Deborah Matthews:** We're working very closely with long-term care and community on the implementation of these physiotherapy changes. There is no question that the old model was a very, very broken model and not resulting in best value for the people who are accessing those services. As I said in my remarks, it was by far the most rapidly growing line in our health care budget. We had to take action. The old model was being abused. That's not a word I would like to use, but it is a word that I do use.

As we implement the new model, we will be watching very carefully. But, as you know, every long-term-care home now gets money for the residents to do physiotherapy for those residents. When you look at other jurisdictions, it is a generous amount of money. But we'll be watching outcomes, because we have the very same goals: We want people to be as healthy as they possibly can be.

When it comes to retirement homes, as I say, we, in our audits, discovered that we were being billed for physiotherapy when a group exercise class was being delivered. That is unacceptable, and we had to change the model. Now everyone's been assessed in long-term-care homes and retirement homes, and they are getting the appropriate level of care and we're paying for physiotherapy as physiotherapy.

I got a note from someone who said, "I've got my new physiotherapist. I had no idea that's what physiotherapy could be." She's doing so much better now because she's getting appropriate physiotherapy and not participation in a group class.

So, as I say—

**The Chair (Mr. Michael Prue):** I'm going to have to stop you there. Hold your thought, and we'll get back to you soon.

The next half hour goes to the NDP: Ms. Gélinas. You have approximately 15 minutes till the bell rings, so your second 15 minutes will be this afternoon.

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**M<sup>me</sup> France Gélinas:** Okay.

**The Chair (Mr. Michael Prue):** The floor is yours.

**M<sup>me</sup> France Gélinas:** I have a list of questions, but I also want to go through some questions that arise from the document you presented. I will start where she left off.

We're talking about a system that grew, in physiotherapy—you quoted: "Billings for physiotherapy increased by 18% to 20% annually." You go on to describe it as abuse and inappropriate OHIP billing. What is being done to recoup this money?

**Hon. Deborah Matthews:** We have asked for the money back that was—through the audit, when we discovered abuse, we've asked for that to be repaid. Have you got anything to add to that?

**Mr. Saäd Rafi:** There are some that are being investigated. They would be under current investigation, where it's quite a dramatic or severe, clear breaking of OHIP requirements.

**Hon. Deborah Matthews:** The thing with OHIP is that there's no cap on the billing. It's not a program. If you bill it, we pay it. There's no cap, unlike other programs. Unfortunately, a small number—and I don't want to tar all of the physiotherapy clinics with the same brush, because it wasn't all of them, but some of them were taking advantage of that ability to bill, unrestricted. That's why we saw that kind of growth.

**M<sup>me</sup> France Gélinas:** I'm interested in—you say a small number. Are we talking one or two providers that are going to be basically followed up on so that they pay the money back?

**Mr. Saäd Rafi:** I'd have to check on the current status. I don't know where we are against how many providers, but there are 96 designated physiotherapy clinics and, as the minister said, the challenges were in the hands of a few only. In some cases, as you know, it's very difficult to collect because it's very difficult to prove that it was inappropriate when it was being billed against a program that didn't have a maximum.

**M<sup>me</sup> France Gélinas:** That kind of sends a weird message out there to people who have to go without other health care services. They have the minister on record saying that here we had people abusing OHIP, people billing OHIP in ways that were inappropriate. Well, this is money that is not available for other types of services that they want and it doesn't seem to be triggering very much time, effort and energy from your ministry to go after that money. This is our money that was sent inappropriately. If anybody else takes money that is not theirs, we investigate and we send them to get the right punishment. How come so little is being done with that?

**Hon. Deborah Matthews:** I just want to say that I think those designated physiotherapy clinics would challenge your assertion that we haven't done much on this, when we have completely changed the model to prevent that kind of abuse and we are going back, where our audit showed there was abuse, to collect that money. That work is underway. I couldn't agree with you more: That money—we need to get the best possible value for every dollar we spend, and when people are taking advantage of their ability to bill, we have to take steps. I don't know what protest you saw, but I certainly saw protest. In fact, I was very disappointed that too many members of the Legislature, in my opinion, did not take the time to understand the issue before they supported the old model.

**M<sup>me</sup> France Gélinas:** Okay. We're in estimates; if I want to follow the money as to how will I know that you have collected back from inappropriate billing, where will that show up?

**Mr. Saäd Rafi:** I'm not sure—probably public accounts with funds collected. I hesitate because I don't think it's that discrete that it would show X dollars collected from X provider of service. We do recoveries on an annual basis. Some of those recoveries are just an inaccurate original allocation. Some of them are recoveries due to audit, as the minister has mentioned. So I have to go back and polish my understanding of what's captured in public accounts and how discretely. It's a pretty voluminous tome, as you know.

**M<sup>me</sup> France Gélinas:** Okay. I'm going to go through your documents where I had made little question marks here. The first one is on page 6. You supported access to pharmacy services in rural communities and underserved areas with new dedicated funding, which I understand to be the higher dispensing fees for rural pharmacies versus the others.

**Hon. Deborah Matthews:** That's right.

**M<sup>me</sup> France Gélinas:** Are there other funds that I'm not aware of?

**Hon. Deborah Matthews:** I believe that is the only additional fee for those in isolated communities. If I'm wrong, we'll let you know.

**M<sup>me</sup> France Gélinas:** Okay. Do you know how many pharmacies there are in Ontario right now?

**Hon. Deborah Matthews:** I know there are more than when we brought in these changes and were told that they'd all be closing.

*Interjection.*

**Hon. Deborah Matthews:** My deputy says that we have more pharmacies than we have Tim Hortons. So there are a lot of pharmacies.

**M<sup>me</sup> France Gélinas:** There are lots. Where I was going after is that it still happened. I'm sure Nickel Belt is not the only place where I saw two locally owned, small pharmacies—one in Capreol and one in Chelmsford—that disappeared. At the same time, I saw a mega Shoppers Drug Mart open up in Hanmer, which is a community close to Val Caron, and I saw a mega Shoppers Drug Mart opening up in Chelmsford. But when we talk about the small, rural pharmacies that were going to be

affected—I can count the ones in my riding because I know them—did you take time to look at who were the independents that lived in the community and that had been serving their communities for a long time, that supported their baseball team and hockey team and that are no longer there? If you don't know how many we are—and I don't care how many Tim Hortons we have. If we don't know how many we are and where they are—

**Hon. Deborah Matthews:** We can find out.

**M<sup>me</sup> France Gélinas:**—then we don't really know if this was effective.

**Hon. Deborah Matthews:** We'll get you the numbers, but I can tell you that there are more pharmacies—we have approximately 3,500 pharmacies in the province. I like to divide a number like that by 100 to see how many on average there are per riding—so about 35 pharmacies per riding would be the average.

**M<sup>me</sup> France Gélinas:** Okay, but it still doesn't answer my question, that the changes that were made were going to affect the small independents. Did it affect Shoppers and Rexall and all of the big ones? I don't have anything against the big ones, but no, absolutely not; they continue to thrive and open throughout Ontario. The effects were going to be felt by the small guy who works in northern and rural and who serves the people that I represent. The effect has been there in my riding. Why would it have been any different? How come it didn't get monitored?

**Hon. Deborah Matthews:** These are companies, right? Whether it's a small company, a small pharmacy or a large pharmacy, business people make business decisions. What I can tell you is that we were very careful about how we developed the formula to determine what those dispensing fees would be for those small and rural pharmacies.

We also made it very clear to people—you know, I meet with the Ontario Pharmacists' Association a lot. They have a chance to embrace a new model of care, so they can deliver flu shots, they can do more MedsCheck, they can do more smoking cessation. They can take advantage of the new models; it's up to them. We are offering that to them. It's up to them to determine whether or not they want to participate in a new model of pharmacy care.

I can tell you, I've had pharmacists tell me that they were thinking about getting out of the business because they just didn't feel they were putting their skills to work, and now they're feeling really excited and enthusiastic about the opportunities to work directly with patients.

We'll see if we have any numbers for you on the number of rural pharmacies, and we'll see what information we have.

**M<sup>me</sup> France Gélinas:** Okay. I agree that they are individual businesses, but when the government makes a significant change and those people come to you and say, "It's going to disproportionately affect people in northern and rural," then I want the government to put a northern and rural lens on their decisions, because it did not affect the big players, it did not affect the urban players, but it did affect the northern and rural players.

1020

**Hon. Deborah Matthews:** So just to be clear, we very much put a rurality focus on our dispensing fees. It's through the rurality index where, if my memory serves me right, the dispensing fee is about 60% higher in those smaller communities. Is it \$7.50 to \$11.50?

**Mr. Saäd Rafi:** I think that's right, yes.

**Hon. Deborah Matthews:** Yes. So we pay a lot more in dispensing fees in those rural communities because we want to support those communities.

**M<sup>me</sup> France Gélinas:** Okay. My next question is also at the bottom of page 6. You've been working with Nova Scotia. "As of September 1 ... we have completed 18 agreements, and negotiations are under way on 15 more." Can I have the list of those 18 agreements?

**Hon. Deborah Matthews:** I don't know why not.

**Mr. Saäd Rafi:** I think so, yes.

**Hon. Deborah Matthews:** In addition, there are the brand names; right. So we're doing generics and brands with a pan-Canadian approach.

**M<sup>me</sup> France Gélinas:** And this is actually giving results?

**Hon. Deborah Matthews:** Oh, it's absolutely getting results.

**M<sup>me</sup> France Gélinas:** Okay. I would be curious to see what are the first 18 and what are the next 15 that are being negotiated.

**Hon. Deborah Matthews:** We'll get you the information that's available on that front. I want to say that, yes, we're getting results. Because Ontario has been pretty aggressive in bringing down the price of drugs, we're benefitting less than some of the other provinces that were slow. But when we actually made those changes to pharmacy and we were able to reduce the price of generic drugs in half—not just for government but for people buying drugs as well—the other provinces kind of took notice and they have all followed. So we've come a long way in a relatively short period of time.

**M<sup>me</sup> France Gélinas:** But to have pan-Canadian is rather new.

**Hon. Deborah Matthews:** Yes. That came out of the Council of the Federation. Premier McGuinty was a real leader in getting his other Premiers to talk about, for the first time ever, pan-Canadian pricing. We had some growing pains. It hasn't been easy to get 13 governments all agreeing, but we've made remarkable progress. I think it saves \$100 million this year—

**Mr. Saäd Rafi:** On the brand.

**Hon. Deborah Matthews:** On the brand side.

**M<sup>me</sup> France Gélinas:** I don't fully understand this process, but at some point, I would like to—I don't know if you're the right person to show me the link between this and the Committee to Evaluate Drugs, if there are any.

**Mr. Saäd Rafi:** I'll just use the brand name side. First off, it's optional for a jurisdiction to participate on a particular drug. So you identify drug A and if a jurisdiction says, "Yes, we want to participate," we ask that they continue throughout the negotiation process.

Each jurisdiction has their own approval process. In Ontario, the executive officer would use the Committee to Evaluate Drugs' efficacious review—so economy, effectiveness and clinical value—to determine whether that drug would be something that may make it on to the formulary. Other jurisdictions may have other methods. They may not use a pure clinical assessment or an effectiveness assessment. They may use another assessment as to whether there's need in their community. So once the negotiated price is established, each jurisdiction goes back to make their own decisions and signs a—

**Hon. Deborah Matthews:** Product listing.

**Mr. Saäd Rafi:** Thank you—a product listing agreement. The Committee to Evaluate Drugs is—they may be called other things in other jurisdictions, but it's unique to Ontario. So we use that before the executive officer does, before—

**M<sup>me</sup> France Gélinas:** You sign on to—

**Mr. Saäd Rafi:** —we sign on to a particular drug to be negotiated. And there's a futures list as well of drugs.

**M<sup>me</sup> France Gélinas:** Okay. The next question has nothing to do with the speech, because I know that I'm going to be running out of time. I'm getting a lot of media questions as to how come you won't be there for the EllisDon vote this morning—that you're here now, but you won't be at question period and you won't be there for the vote?

**The Chair (Mr. Michael Prue):** It's not really part of estimates, and I don't know whether I can allow the question.

**Hon. Deborah Matthews:** I'll happily answer the question, but maybe afterwards.

**The Chair (Mr. Michael Prue):** Okay. It's up to you, but the question has nothing to do with estimates.

**Hon. Deborah Matthews:** No. I had a previously scheduled celebration of a \$50-million donation to hospitals, and so I will be there celebrating an extraordinarily generous gift.

*Interruption.*

**M<sup>me</sup> France Gélinas:** I guess this bell rings for us?

**The Chair (Mr. Michael Prue):** Okay. We're going to recess now till this afternoon. When we come back, the NDP has 15 minutes, and then the minister has 23 minutes for a reply.

I'll see everybody here at approximately 3:45. We are recessed.

*The committee recessed from 1025 to 1550.*

**The Chair (Mr. Michael Prue):** We will call the meeting back to order. When we recessed prior to question period this morning, Ms. Gélinas had the floor. You have an additional 15 minutes.

**M<sup>me</sup> France Gélinas:** And a half.

**The Chair (Mr. Michael Prue):** The Clerk advises me it's 15.

**M<sup>me</sup> France Gélinas:** Okay.

I'm still going through the document that you tabled this morning, and I'm on page 8. It goes, toward the middle of the page: "Going forward, the 2014 physician services agreement negotiations present an opportunity to

work with physicians on a joint vision for the future and the right incentives for the best care." I'm just curious. Does that mean that we can expect to continue to see incentive pay for physicians to do things they should be doing because it's the right thing to do for good patient care?

**Hon. Deborah Matthews:** We, of course, only had a two-year agreement with the OMA last time, so we are looking to begin those negotiations. There are things where we think it is the right thing to do to put in place the right incentives. House calls are a really good example of where we're actually prepared to pay a little bit more to a physician who is going to do house calls—over a certain threshold—because it's better for patients and it's significantly more time-consuming for those physicians. Getting those incentives aligned is very much what we want to be doing.

In the last agreement, we added an additional payment for people with more complex needs, because what we were finding was that physicians wouldn't take those patients with complex needs because it simply didn't make sense for them. Patients who require very frequent visits, we were finding, sometimes couldn't get a doctor. That's why we have an open mind to add incentives for the behaviours that are best for patients and give us the best value for money.

**M<sup>me</sup> France Gélinas:** Does that mean that the negotiations won't include paying physicians on salary?

**Hon. Deborah Matthews:** No. We've actually done a really good job. I think we're leading the country in blended models, capitation and what we call—AFP? APP?

**Mr. Saäd Rafi:** Both.

**Hon. Deborah Matthews:** Both, so plans where we pay emergency room doctors, for example, not on a fee-for-service but for a shift. Sick Kids Hospital has all of their physicians on a fixed income, regardless of how many procedures they perform. We're moving more in that direction, and we're looking in the future to do more of that.

**M<sup>me</sup> France Gélinas:** Okay. I'm now at the top of page 9, where you said: "Through quality-based procedures, where targeted health services are funded on a price x volume basis"—I get it. I'm not always sure as to how you set the bar. Why is it that sometimes procedures will be funded at 50%? Otherwise, it's funded at the 65% average for that procedure, or sometimes it's the 70% average. Sometimes it's the 50% average for that procedure. How are those decisions made?

**Hon. Deborah Matthews:** This has been the very difficult and challenging work of ministry officials. I think the whole sector agrees that this is the right way to go going forward, but getting those prices right is part of what I would say has been an excellent process of making determinations.

What we learned was that a lot of hospitals don't even know what their case costing is, so they didn't know what it was costing them to do cataracts; they didn't know what it was costing to do a hip replacement. So



we've had to work with our hospitals to get the right metrics and land on prices. We continue to negotiate with hospitals on getting that right.

**M<sup>me</sup> France Gélinas:** How will you manage the fact that as more and more procedures will be done in the community, the community side can very well turn people away and send them to the hospital to have a procedure done? The hospital, of course, won't turn people away; they will take them all. So you end up with all of the heaviest patients—the one who is blind, who doesn't speak the language, who is hard to care for, who has comorbidity; they all end up in our hospitals, and the cases that make money all end up in the community-based, physician-owned practice. But yet the hospital and the physician-owned practice get paid the same price times volumes.

**Hon. Deborah Matthews:** There is a complexity modifier in the QBPs so they do get a higher fee for a more complex case. So a knee replacement, for example, if it's a second knee replacement, they actually will get more than if it's the first time, because it's a more complex procedure. These are all issues that we're working out as we implement QBPs.

Maybe the deputy can add—

**Mr. Saäd Rafi:** If I could just add, we actually want that scenario, in a manner of speaking, because the ambulatory patient would be easier to care for outside of a hospital environment and she would not be exposed to all manner of other challenges in a hospital environment. So we're trying to set differential prices for 30-plus—I think up to 34—different procedures.

Then we also need to track where those volumes are taking place across the province, because in various nodes in the province, we may want to coalesce those volumes in a hospital—or if it's cataracts, in a clinic—but we will pay based on the price and the volumes allotted to that clinic. So for a straightforward cataract operation without complications, as the minister said, we'll pay X dollars—I'll make up a number; \$500 times these volumes—and so you can't go above those volumes. Through experts in the field on vision care, for example, we know where all cataract volumes took place in Ontario, so now it's a matter of saying, "Should we coalesce those volumes at a particular locale?" The reason for that would be that higher volumes of procedures means better quality. Think of basically moving around these services, within a pretty tight catchment area, because we also have to be cognizant of how far patients are prepared to go—and physicians.

It is a complex landscape, but it's not a bunch of bureaucrats making those decisions. It's being entirely advised by experts in the field of cataract, of unilateral knee, hip, COPD etc.

**M<sup>me</sup> France Gélinas:** Okay, because if you look—I know I'll be coming to questions about small and rural, but if you look at small and rural hospitals, and I'll speak mainly for northern Ontario, where they used to do hip and knees, they certainly did not do the volume that anybody down south would do, but they were providing a

quality service to the people of, in this particular case, northwestern Ontario. There is no way they can do it at a price that UHN could do because they do very few. Now those people have to travel 600 kilometres to go to Thunder Bay to have those surgeries done.

**Mr. Saäd Rafi:** That's not the idea. We are exempting certain-size hospitals for that very reason. It's more of a true community-based hospital, where they must take all and sundry requirements. When they get very complicated, of course, you'll want to take advantage of higher specialties with better equipment etc.

**1600**

We're not trying to suggest that, again, my fictitious number of \$500 for a cataract will take place everywhere in the province. We have to recognize, just as we're not applying the health system funding reform to all 152 hospital sites—they're for about 89, and that's for different reasons. Mental health is not yet sorted out. We're working with the mental health facilities. We're working with the pediatric facilities, and the small rural are exempt because of the points you've made.

**M<sup>me</sup> France Gélinas:** When you use the term "through community-based hospital," what were—

**Mr. Saäd Rafi:** True; I meant a true community-based hospital.

**M<sup>me</sup> France Gélinas:** That's my accent coming through here.

**Mr. Saäd Rafi:** I'm sorry.

**M<sup>me</sup> France Gélinas:** I meant the same word you said.

**Mr. Saäd Rafi:** My apologies.

**M<sup>me</sup> France Gélinas:** What do you mean? What is it?

**Mr. Saäd Rafi:** What I mean by that is we don't want to arbitrarily say, "Well, look, we've decided that everything south of the French River has to be done in an ambulatory setting for cataracts," when there are people in other communities who would need those services. We have exempted certain hospitals because they are providing a service for all the members in their community, so that's what I mean by a true community hospital. It provides everything for that community. To just simply make it into a, I don't know—to pick two or three very complex services would be the wrong thing to do.

I didn't mean to suggest—and I probably misspoke when I said cataracts was an example—that we would map the entire province and move those volumes around. In some places, it's just not going to be possible because the distance that that physician will have to go and the distance that patient will have to go is unreasonable.

**Hon. Deborah Matthews:** The other point I wanted to make is that we are really working with the sector. We're not imposing; we are working with the sector. Some hospitals have decided that they don't want to do certain procedures anymore, that their patients can be served in another place, that they can get high-quality care at another place in the same community, and we're talking—a lot of this is Toronto, right?—where there are a number of different hospitals. So the hospitals are

making decisions about actually shifting volumes out, to Kensington, for example.

**M<sup>me</sup> France Gélinas:** Okay. I'm now on page 10, and we're talking about how "We also annualized our \$20 million transformation fund for small and rural hospitals to help them improve patient care."

The transformation fund is the same limits that were put on the original \$20 million as to what hospitals could apply and could do with that \$20 million. Are the same restrictions going to continue now that you have annualized it?

**Mr. Saäd Rafi:** Well, I would not like to use the word "restrictions." I would say the same method of allocation will be applied, which is through the hospitals in conjunction with the LHINs. That was to identify, I think, 75 project-based initiatives. That came from the ground up, not from restrictions applied. Some of those initiatives may be time-limited; some may continue beyond a year and into a couple of years. We'll have to take a look at which are time-limited, which continue on and what else those facilities may want to undertake because this money was for them to dictate what works best in their community because we did recognize—

**M<sup>me</sup> France Gélinas:** Except that some of them did not want a project base. Some of them just wanted to stabilize their funds, just wanted to stabilize what they already had. To do this, they needed extra funds, but none of that fund is available to small and rural hospitals to stabilize their base. The fund can only be applied to for a new project or an expansion of a project.

**Hon. Deborah Matthews:** All the small, rural hospitals got a 1% increase, unlike the other hospitals. They all got 1% to help them with that. This money is very much intended to support transformation.

We saw some fantastic projects that actually do help these small hospitals take advantage of technology. Some of the bigger hospitals have budgets where they can actually invest in projects that these small hospitals just can't. To put together a proposal, lots of them are using a collaboration with other health care providers, whether it's home care or primary care or whatever.

We want this money not to be base money; we want this money to be used to support transformation because we want to keep those small hospitals vibrant and fulfilling an important function in those communities. We don't want them to become less and less relevant, so they need to do things differently. This money, which was your brainchild and worked so well that we chose to do it not just one time but to annualize it, was to support transformation.

**The Chair (Mr. Michael Prue):** I'm going to have to stop you there because the time has expired. It's now back to the minister and the ministry for 23 minutes.

**Hon. Deborah Matthews:** We have a slide deck. Have you got the slide deck? I believe you do.

**The Chair (Mr. Michael Prue):** I think it arrived as you spoke.

**Hon. Deborah Matthews:** So I'll get started, because you can catch up, I think. We put together a presentation

to give you a bit of an overview of some of the things that are going on.

You've heard me talk a lot about transforming the way care is delivered in the province. We are undertaking an unprecedented scale of change. Our system is a \$49-billion system, and the change that is under way now is more than just tinkering around the edges. We are changing how we deliver care in the province. We're re-designing the health care system to put people, not the organizations, at the centre of the system.

I have to say that the collaboration in the health care community is nothing short of phenomenal. Many people are engaged around health system funding reform. The LHINs have really led this, as have other health sector leaders. What we have is a system that is ready for change. We have advances in technology that are improving patient care. And we've got a very robust body of evidence on better care for patients and we're applying that evidence.

I talked earlier about the challenges, and I think everybody recognizes that we do face challenges in our health care system. I think we all recognize we have a fiscal challenge. We've been growing the health care budget at 6% to 7% annually. Now we're down to 2%. As I said, as far as the eye can see, I don't see much more than 2% any time soon.

The demographic challenge is real. We're living longer. We're reaching the age, us baby boomers, where we'll need more from our health care system. We've got some complex problems where we have a relatively small number of people who have complex health problems and they're not getting coordinated care; they're not getting the best quality care collectively. And we're not as healthy as we could be and should be.

The next slide is about the fiscal challenge. You can see that the government is intending to hold annual growth in program spending to 1%. Health will be at 2% because we do have responsibilities to the people. We're 42 cents of every dollar that government spends, and if we don't change how we deliver care, health care spending will be at about 70% of our health care budget within 12 years, which means we simply could not spend on other things that matter to people. As I say, the good news is that we have been able to bend that cost curve down, and we're doing it at the same time as we're improving the quality of care for patients.

The demographic challenge: The next slide is, I think, a slide that gets the attention, because what it demonstrates is that if we did nothing differently and we only were providing care to people at the same rate we do now by age, the demographic change by 2013 would mean we'd have to increase our budget by 50%, not including inflation, not including any enhanced technology and the costs that go with that. So that gets our attention.

The next slide deals with the idea that there are relatively few people who are really costing the system a lot. They need the system a lot. So 1% of people consume one third of our health care dollars; 5% use two thirds of our health care dollars. We know that we can

provide better care for those folks at lower cost if we coordinate the care around them.

We're tackling our health care challenges by trying to provide more timely and effective care to people who need help the most. We need to better manage spending for populations with complex health problems, those with multiple chronic conditions, including mental health. We know that too many people are getting the care they need in a hospital when they could be cared for better in the community. Access to primary care is uneven—much, much better than it was, but still, many people are not getting the benefit of a coordinated care plan. Wait times for specialty services and for long-term-care homes are still too long. If we were to even save 10% on those complex patients by enhancing the quality of care, by providing more coordinated care, we could save close to \$2 billion.

#### 1610

We're not as healthy as we should be. Twenty-five per cent of our costs are due to preventable illness. Nearly half of all cancer deaths are related to tobacco use, diet and physical activity, and the member from Nickel Belt has made that very clear this morning. We have to exercise more, quit smoking, eat better and maintain a healthy weight—and we reduce our risk of cancer, I think you said, by 80%. These are in our control; we need to help people. We've got a serious challenge with obesity, and that causes heart disease, type 2 diabetes and a range of other conditions.

We also have far more people going to emergency departments when they should be able to get that care at a lower cost outside the hospital, often from their primary care provider, if that provider would provide same-day or next-day appointments.

Our vision: Our goal is to make Ontario the healthiest place in North America to grow up and grow old. We're going to do that by providing better access and faster access to family care. We're going to have better quality, ensuring that care is patient-centred, driven by outcomes and based on evidence. I have to say, I was very surprised to learn how much of what we spend on health care is not evidence-based. And we need better value; we need to improve the value that Ontarians gain from our investments in health care.

We have a plan. We want Ontarians to have more support to be healthier, with faster access to care and the right care at the right time in the right place.

You can expect to see a relentless focus on the use of evidence to improve quality. I have to say, there will be resistance. There is resistance to this, but we simply don't have a choice. We must invest in those things that have demonstrated benefits to patients. We can't afford to spend on things that do not have demonstrated improvement outcomes for patients.

We will see a measurable shift in where and how services are provided, and we will manage our growth in our spending.

Our goal 1: keeping Ontarians healthy. That's helping people stay healthy. Twenty-five per cent of health costs,

as I say, are due to preventable illnesses. Nearly half of cancer deaths are related to tobacco use, diet and physical activity. Currently, about one third of eligible women still do not have a mammogram. Nearly one in four do not have a Pap test within the recommended time frame. So there's a lot to do on keeping people healthy. We also are focusing on reducing rates of smoking and keeping our kids healthier.

Goal 2: faster access to family care. We are speeding up access to family health care—a range of actions in this area. Health links; same-day and next-day access to family care; house calls; and quality improvement in the community are a few of the ways we're working with our partners in primary care to make the system work better for patients.

The right care at the right time in the right place is a big piece of transformation, and there are many moving pieces. When it comes to acute care, we're freeing up hospital resources to focus on acute care. As our ALC rate comes down, that means hospitals can care for more people who need to be in hospital. In the community, we really are strengthening the community sector's capacity to deliver a broad range of services. Long-term care: We're shifting some capacity towards short-stay, acute-level interventions to alleviate pressures elsewhere in the system, and we're seeing terrific success on that front.

When it comes to primary care, we want people to go to their primary care provider first. That should be where people go first, and they should go to a hospital only if that's necessary.

When it comes to drugs, we need to ensure that people have access to the drugs they need, but we also need to reduce the dangers of duplicate prescriptions and overmedication.

Mental health and addictions is huge. Building more collaboration across sectors means we can deliver timely access to mental health and treatment services.

And home care, of course, is probably our number one priority. We are expanding personal support workers through community agencies that now can deliver PSW care to low-needs patients.

Our action plan creates a system that improves quality care for patients and delivers more value for taxpayers. Guided by the action plan, there are four pillars of work to support transformation. These pillars do not operate in isolation; they build off each other. They work together to prevent serious health issues from happening in the first place, prevent or better manage chronic conditions and create a stronger, more integrated system that serves patients more effectively. The pillars are: wellness and prevention; health system funding reform; right care, right time, right place; and integration.

With a focus on wellness and prevention, we're empowering people to make healthier choices, and we're really focusing on children. We need to have healthier kids. So we're helping people stay healthy. We're supporting Ontarians with information and tools to make healthy choices. We're encouraging Ontarians to be more proactive in protecting their health, and we're focusing

on preventing and better managing chronic conditions that contribute to serious health issues for people of all ages.

The Healthy Kids Panel released a report on how to reduce childhood obesity, and our implementation plan is now under way. I was very interested to learn that the evidence says that supporting people in breastfeeding is one of the best things we can do to have healthier kids. Our goal is that every mom in the province who wants to breastfeed her child will have the supports to be successful in doing that. We've also announced that we are going to list calorie content on menus and menu boards, and we're enhancing supports for our Student Nutrition Program.

You all know we've passed legislation to reduce youth access to tanning facilities, and we want to strengthen efforts around tobacco controls for youth and expand cessation programs.

We're giving Ontarians the tools they need to take ownership of their health and manage illness. We're encouraging Ontarians to be more proactive, and we've got a number of things under way. One example is the social smoking campaign. This campaign has gone viral. The thinking behind it is a lot of people start out as what they call "social smokers," and they become full-time, full-on smokers.

We are, as we've talked about, funding reform. We are reforming how we fund health care services to drive quality, efficiency and effectiveness in our system. We're working to better design services around patients' needs.

My two favourite questions on any change that comes before me are, is it better care, and is it better value? So if a change means better care for patients and better value for those precious dollars, then we have to figure out a way to do it.

On the health system funding reform, we're moving from global funding. Any of you who have tried to unravel why a hospital gets a certain amount of money will know that it has been impossible to actually explain to someone why a specific hospital gets a specific budget. So we're shifting that. We're shifting from global spending to health system funding reform. It's more transparent. It's evidence-based. Funding is tied more directly to the quality of care that is needed and will be provided.

So why now for health system funding reform? There are a number of advantages. It improves the way that we meet the needs of communities. It will accelerate the move toward a fairer, more evidence-based approach to funding that better responds to emerging health care needs as built-in incentives to encourage the delivery of high-quality care. There will be a more transparent link between the funding and the delivery of care. Funding will shift from being historical to one where it's allocated based on the type and quality of services provided. Funding reform will link funding to service delivery and outcomes so there will be appropriate incentives to reduce length of stays, reduce wait times and improve care.

**1620**

Our expenditures have risen rapidly over the past decade. This will help to moderate health care spending and ensure our health care system is sustainable. We are learning from other jurisdictions who have done this. In fact, Ontario is by no means the first—closer to the last than the first—to implement this funding reform.

Two components to health system funding reform: HBAM, the health-based allocation model. It's a funding model that determines the optimal amount of funding based on patient demographics, age, gender, growth projections, socio-economic status and geography. It's based on clinical data, complexity and type of care, and financial data. The second part of health system funding reform is QBPs, because we love acronyms in health. These are specific groupings of health services. You can see on the list what—the first round of QBPs were chosen based on their potential to drive better-quality care at an evidence-based price. More QBPs will be added in coming years in hospital and community settings.

As we've talked about, institutions are funded on a price-times-volume basis. By April 2015, health system funding reform will account for approximately 70% of hospital funding. We are phasing it in over time because it is a big change for the sector and we don't want to be any more disruptive than we have to be. We're talking about hospitals, but we are also bringing in health system funding reform to include more of a community focus. Each year, global funding is reduced in proportion as HBAM and QBP increase, but global funding will not go away altogether; it will still be used to determine funding for activities that can't easily be modelled or that are otherwise unique—for example, small hospitals and forensic mental health.

When it comes to quality improvement, we actually are demonstrating that when we lead with quality outcomes and safety, we do see lower costs. Higher-quality care is lower-cost care. We can work together as a team to achieve the end goal: some cost reduction, and high quality and safety.

Here we have Rob Devitt, president and CEO of Toronto East General Hospital. I think our Chair knows him well—

**The Chair (Mr. Michael Prue):** Very well.

**Hon. Deborah Matthews:** "Very well." What he says is, "The beauty of health system funding reform is that it identifies, province-wide, the clear measurable outputs of an episode of care."

As I say, this is not easy for the hospital sector and for other health sectors, but they know it needs to be done. We are really focusing on getting the right care at the right time at the right place. We are shifting services to more appropriate and cost-effective settings and optimizing existing resources. We're improving quality for patients.

You will remember that we unanimously passed the Excellent Care for All Act, which really is driving quality improvement. We're shifting procedures. We're building

community capacity. We know that older Ontarians would rather age and receive care at home as long as possible. With the right supports, this can be done for many. We really are working to keep long-term-care homes as a place for people who really need that high level of care.

Our Seniors Strategy, of course—Dr. Samir Sinha had a number of recommendations. His report is called *Living Longer, Living Well*. One of the recommendations that we're implementing is to ensure that every senior who wants a primary care provider gets one. We are providing 200,000 more people with exercise, falls prevention and improved access to high-quality physiotherapy, and expanding house calls. And we are looking at the role of long-term care. We're looking at their role and the opportunities to use those homes, those existing resources, those existing trained people for people who need shorter stays. So we are adding 250 short-stay beds, in addition to those that were already there.

We are, as we've talked about, committed to shifting low-risk procedures from acute hospital settings to non-profit, specialized, community-based clinics. We have good evidence that these clinics that focus on a few select procedures can serve more patients more quickly, with excellent outcomes. We are building on the success of clinics like the Kensington Eye Institute. We've expanded services at Kensington. We have two midwife-led birth centres. It means people spend less time waiting for procedures. It's more convenient and easier access for patients. The ministry, LHINs and Cancer Care Ontario are working together to roll out specialty clinics, starting with routine cataracts. In future, other procedures that don't need overnight hospital stays, like colonoscopies, could also be done in specialty clinics. They will operate under existing legislation and quality assurance frameworks that ensure quality, oversight and accountability.

We're strengthening coordinated care to improve access to health care services. We're maximizing value and enhancing quality, with an emphasis on primary care and seniors.

**The Chair (Mr. Michael Prue):** You have one minute.

**Hon. Deborah Matthews:** Thank you.

LHINs: LHINs have done a terrific job improving the integration of the health care system at the local level. Care is more cohesive. Providers are working together more. This is the beginning of an evolution toward better integration and system accountability for improved patient outcomes. However, if we are to meet the needs of a growing population with multiple complex and chronic conditions, our health care system must be even better coordinated, with seamless levels of care. Partnerships that are needed go far beyond a relationship between the LHIN and a hospital, or a hospital and a CCAC; it needs to include the patient at the centre and all community providers.

Why don't I stop there.

**The Chair (Mr. Michael Prue):** With that, I thank you. And if you want to continue with this, perhaps the

government members can ask such a question. But for now, it's back to the Conservatives. You have 20 minutes.

**Mrs. Christine Elliott:** Thank you, Chair. Good afternoon, Minister. I'd like to go back, if I might, to your presentation from this morning. I do have a few more questions arising out of that. If I could turn again to page 15, which was dealing with the physiotherapy cuts, you've indicated in the second paragraph that, through audits, you were made aware of the depth of inappropriate OHIP billings. Would you be able to provide those audits to us?

**Hon. Deborah Matthews:** Let me see what I can do on that front.

**Mrs. Christine Elliott:** You indicated also that it was a small number of physiotherapy clinics that were billing inappropriately. Why did you feel the need to change the entire system? Why not just deal with those providers rather than deal with it the way you did?

**Hon. Deborah Matthews:** I want to say that the clinics provided service. We did not see the terrific growth in billings from those clinics. We offered all of the existing designated physiotherapy clinics an opportunity to participate in a new model, and I think all but a handful—maybe two or three—chose to continue to participate with us under the new model. So not only are we keeping the existing clinics that provide government-funded physiotherapy, but we're more than doubling the number of clinics to provide access right across the province.

So the clinics weren't the problem. The problem was when these companies were going into, particularly, retirement homes and billing us for physiotherapy. When we did that audit, we discovered—and I had whistleblowers who came forward and talked to me about what was happening. I had one email from a woman whose mom was in a retirement home. Her doctor recommended physiotherapy for the mom and was shocked to find that she had exhausted her physiotherapy. She had no idea that she was being billed for physiotherapy when she was participating in group exercise classes. I heard from a range of people.

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The fact that these changes were supported by the Ontario Physiotherapy Association tells you a lot—when that profession says you need to change the model. That had a pretty big impact on me.

**Mrs. Christine Elliott:** Well, again, I'm hearing from individuals about their concern about their parents being cut back on the actual amount of physiotherapy that they're receiving. The fact that some of these services are now going through the CCACs, which have a 30%-plus overhead rate—it concerns me that we're not getting as much direct service as we should be under the new model.

**Hon. Deborah Matthews:** Oh, that's simply not true, and I would urge you to talk to your CCAC about that.

Just to clarify, the CCAC overhead and administration is less than 10% of their budget. There is, I know, some debate about whether care coordination is front-line care.

I can tell you that without care coordinators, home care would not work. So the CCACs are providing in-home physiotherapy, which is what they've been doing for some time. They're assessing people and providing that care.

As I said earlier, 12 of the 14 LHINs have eliminated their wait-list for in-home physiotherapy because of the infusion of funding under this new model, and the other two are getting close. So that's great for patients.

**Mrs. Christine Elliott:** Well, I guess it does depend on how you define "care coordinators" and whether they fit into administrative staff or front-line staff, but I guess we might have to agree to disagree on that at this point.

I'd like to next take a look at page 17, if I might. You were speaking about "planning calls for proposals to establish non-profit specialty clinics...." I notice that it is specifically non-profit. Did you examine the idea of allowing for-profit clinics to provide the service, and why did you determine only non-profit?

**Hon. Deborah Matthews:** We did consider for-profits, but we have a publicly funded health care system, and I think it's important to keep as much in the non-profit as we can. There are ways that organizations can establish non-profit clinics. I would rather the money went into care than into profits.

And just to be clear, Kensington is a not-for-profit.

**Mrs. Christine Elliott:** Yes, I'm aware of that. Thank you.

On page 19, you were speaking about long-term-care homes and speaking about redeveloping 35,000 long-term-care beds. I understand that there has been a problem with uptake in the sense that many of the long-term-care operators are concerned that there isn't a business case to be made there for proceeding with the redevelopment. Are you taking a look at this now to encourage the further redevelopment of the B- and C-level homes, particularly in rural areas?

**Hon. Deborah Matthews:** Absolutely. We were not happy with the uptake of the first round, so we did go back and did a market sounding on what prevented people from putting forth proposals. Maybe the deputy could expand on that.

**Mr. Saäd Rafi:** Yes. So we're doing a few other things as well from the market sounding. There were some irritating and regulatory issues that home providers identified, and so we're trying to deal with some of those.

One of them was to try to encourage CMHC to get back into the mortgage insurance part of their business for long-term-care homes. I believe they have left all provinces and they're not providing those suites of services, and some long-term-care home providers felt that that would help them in financing.

Another area was that we're examining the concession or the licence period. Perhaps if we gave a longer licence period, it might help for financing. As well, for the redevelopment, some B and C beds might have five to seven years left in their licence, and if a redevelopment cycle takes a couple or three years, that's a deterrent or a

lack of encouragement. So we were thinking of perhaps looking at renewing licences earlier.

We're working through the Ontario Long Term Care Association's recommendations as well on some things we can do—a development office that you may be familiar with in the past, as well as having to take a hard look at the accommodation component in the per diem.

**Mrs. Christine Elliott:** Can you tell us when you expect the new rules to come forward?

**Mr. Saäd Rafi:** No, because I haven't had a chance to put together sort of a suite of responses and bring it forward to the minister and the government, but on some of the things, we've already started conversations with CMHC. They're having their challenges. They want certain conditions that we aren't at this point able to provide.

We're also trying to—we're mapping where our wait-lists are for B and C beds with existing properties government might own, and that's just started, as well, to see where there might be opportunities to encourage developers and also to encourage them for multi-use. That was part of the market sounding. For example, would they be willing to put in market-rent-type units along with long-term-care-home units, where we would provide a long-term concession which would help to finance the other units in a high-rise, for example?

**Mrs. Christine Elliott:** Okay.

**Mr. Saäd Rafi:** So it will take several months for us to work through some of these ideas.

**Mrs. Christine Elliott:** Several months, then. That's somewhat encouraging, because there is a significant concern, as you know, in the sector, so as soon as possible would be great.

**Hon. Deborah Matthews:** And we are absolutely committed to that redevelopment. We just need to make it work.

**Mrs. Christine Elliott:** Great. All right, thank you.

I'd next like to ask a few questions about the mental health strategy, if I might. Just for starting off with, how much money has been invested in the strategy to date?

**Mr. Saäd Rafi:** Could I get you a definitive number? I'm not confident with what I see in front of me.

**Mrs. Christine Elliott:** All right.

**Mr. Saäd Rafi:** I've just been given the exact same page. I'm still not confident.

**Mrs. Christine Elliott:** Certainly, if you could let me know.

**Mr. Saäd Rafi:** Sorry. I will.

**Mrs. Christine Elliott:** And you might have to check on my next question, as well. I'm just interested because it is, as I understand it, an integrated strategy, the first three years being spent primarily on children's initiatives. I'm wondering if you have a breakdown of how that money has been invested into each individual ministry so far—education, children and youth, health—just so we get an understanding of where we are with it.

There's also been an initiative that has been started through the Ministry of Training, Colleges and Universities with respect to students' mental health. I'm wonder-

ing if that is part of the overall strategy, or is that something that has been purely an initiative separately—where that fits into your overall strategy.

**Hon. Deborah Matthews:** You're talking about the 24/7 line that students can call?

**Mrs. Christine Elliott:** Yes.

**Hon. Deborah Matthews:** That is an initiative of TCU. It's complementary to our strategy, but it's not part of our strategy.

**Mrs. Christine Elliott:** All right. Thank you.

And can you tell me where most of the investments have been made so far in the area of children's mental health, which is the first priority, not necessarily in dollar amounts, but where all that money has been going?

**Mr. Saäd Rafi:** A large component would be in education, in school boards, in actual schools, for mental health services. Some of it would be with the Ministry of Children and Youth Services and in some First Nations communities as well, and also through the Ontario Mental Health Foundation. The Canadian mental health foundation has some elements of those funds as well.

When we give you the breakdown, we'll be able to show you by delivery agent.

**Mrs. Christine Elliott:** All right. Now, I understand that a lot of those funds are for identification so that nurses and mental health workers can identify needs of children in schools. What I continue to hear about is the lack of treatment facilities, and I'm wondering if you can tell me what the plan is for developing the facilities, either that we have or that you intend to invest in.

**Mr. Saäd Rafi:** I will have to get you that. I'm not sure how much money was put into facilities in the first instance. It was to identify not just cause or need but also to help with treatment modalities, and then that would lead you to where they would receive that treatment. But I'd have to also get back to you on that.

**Mrs. Christine Elliott:** Can you tell me the length of the wait-list now for residential placements for children?

**Mr. Saäd Rafi:** I don't know.

**Mrs. Christine Elliott:** Would you be able to provide me with that information?

**Mr. Saäd Rafi:** I'll try to get that to you, yes.

**Mrs. Christine Elliott:** Because anecdotally, we're certainly hearing that the wait-lists are extremely long and that parents are becoming very concerned about what will happen to their children. If you have a two-year wait-list with a suicidal teenager, it's simply not possible to continue to wait.

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**Hon. Deborah Matthews:** We will get you an update on the implementation of the first three years of the mental health and addictions strategy.

**Mrs. Christine Elliott:** Can you tell me what the plan is for the rollout of the next phase of the strategy?

**Hon. Deborah Matthews:** We are in deep consultations with a range of people who work in the adult mental health and addictions field about where they see that we need to go next, in the next 10 years. That work is very much under way. My parliamentary assistant has been

very engaged in this as well. We're doing that work right now and look forward to the release of the next years—what we call four through 10, four-plus.

**Mrs. Christine Elliott:** All right. Certainly that's important, but if I could go back to the children's mental health issue and residential treatment. Are you studying right now the idea of building capacity in existing facilities so that we don't need to continue to send children primarily to the US for treatment?

**Hon. Deborah Matthews:** We'll get you out-of-country data for mental health. I don't believe it's particularly common to do that. I believe the Minister of Children and Youth Services would be the one who could answer that.

**Mrs. Christine Elliott:** All right. But it is part of the overall strategy, for which you're ultimately responsible.

**Hon. Deborah Matthews:** Yes. It's a collective responsibility, but yes.

**Mrs. Christine Elliott:** I'm just concerned that we need to do something for those children, that either we build capacity in some of the existing facilities that we have that provide excellent service, or we need to consider new builds. The reality, as I'm sure you know, is that people who have a lot of money are sending their children to the US because they can't wait for treatment here. But then if you don't have the money, what do you do? I'm just very concerned. I hear from my constituents about that on a regular basis. I'd really like to know more about what the plan is for children's residential treatment facilities.

**Hon. Deborah Matthews:** You'd be interested to know that we're seeing, in SickKids hospital, for example, their length of stay on eating disorders has come down dramatically because they can provide care on an outpatient basis, freeing up those beds for more people. It's not just a matter of expanding capacity; it's getting the right length of stay and the right supports, most importantly outside the hospital.

**Mrs. Christine Elliott:** The other issue that I'm hearing more and more about in my community is the lack of facilities for people who are dually diagnosed, that it is a major concern that many conventional treatment facilities don't offer service to that population. Can you tell me what the plan is for that group as well, please?

**Hon. Deborah Matthews:** So I think you hear in your community what others hear in other communities. That is a focus of our strategy going forward.

**Mrs. Christine Elliott:** I look forward to hearing the details of that.

Next I have some questions regarding community care access centres. Obviously CCACs were set up to ensure value for money and to coordinate home care services by evaluating bids to get the best value for money. But recently CCACs have been doing direct hires of nursing and other service providers. Can you tell me why that decision was made?

**Mr. Saäd Rafi:** So the direct service—I'm not sure I'm familiar with that. I do know that they have had to

suspend the provision of services from some contract providers because of poor quality. That has been something that we have allowed them to do, where then they would go out and try to secure either a neighbouring supplier of home care services or look for an alternative provider to come into that space in that market. That has been sometimes due to poor quality and poor delivery. They have been monitoring that and trying to make those changes.

**Mrs. Christine Elliott:** I also understand, though, that there have been some deliberate decisions made to do direct hires, primarily of nurses. I'm wondering what the rationale is for that.

**Mr. Saäd Rafi:** I'll have to look into that. I'm not familiar with the direct hires as individuals, as opposed to a St. Joseph's or something like that.

**Mrs. Christine Elliott:** That's right. I understand that it is being done across all of the CCACs in the province, so I would appreciate some—

**Hon. Deborah Matthews:** I think there was some dedicated funding for a particular reason, so we'll get back to you on that detail.

**Mrs. Christine Elliott:** Okay. Would you agree that it would be a conflict of interest to have direct hires when the reason why the CCACs were set up in the first place was to ensure the best value for the money and to encourage that kind of competitive bidding?

**Hon. Deborah Matthews:** I would not see it as a conflict, depending on the function of those hires. Our CCACs overwhelmingly use third parties to provide service. We've changed the tendering process so that it's not disruptive, as it was before, so as long as certain quality standards are being met, those contracts can be rolled over.

Can you be more specific about those direct hires?

**Mrs. Christine Elliott:** I understand that there have been nursing services, primarily, that have been directly hired by the CCACs and not through the community service providers.

**Hon. Deborah Matthews:** I think it was a very specific program, very small numbers.

**Mrs. Christine Elliott:** Would you agree, though, that otherwise it would be a conflict of interest if you're doing direct hires?

**Hon. Deborah Matthews:** I don't see it as a conflict of interest, but I would respect your perspective on that, so I'd like to learn more about why you think it is.

**Mrs. Christine Elliott:** Certainly what I've heard from the community service providers is that they are losing staff to be directly hired through the CCACs, because they pay more and they have more benefits. I can't understand how there would be value for money if the CCACs are paying over the rates that the community service providers pay for the same job.

**Hon. Deborah Matthews:** Let's get the facts on this one.

**Mrs. Christine Elliott:** Okay. I'd appreciate further information on that.

**The Chair (Mr. Michael Prue):** You have about one minute.

**Mrs. Christine Elliott:** All right. I have one last question, then, on palliative care hospices. I understand that currently your ministry funds 28 of them, yet there are 11 of them where the hospices have not even been built. I'm wondering if you can tell me what the money is being used for and where it is going.

**Hon. Deborah Matthews:** Sure. It's being used for palliative care. When the decision was made, back when George Smitherman was Minister of Health, to fund hospices, the decision that was made then was to fund existing hospices, whether or not they had a residential hospice. In London, for example, we have a hospice but it's not yet residential. It's going to be residential. It provided hospice care in the homes of people who were receiving palliative care.

That money went to the LHINs, and the LHINs used it for palliative care outreach in a non-residential—but it was always earmarked and attached to that hospice. Several of them—Bruce-Grey-Owen Sound; I'm not sure about the one in Mr. Clark's riding.

As we're seeing more communities build hospices, that money can be used to fund partially, because we do not fund all of the costs of a hospice. We do fund the nursing care in a hospice; that money can be used. This is all part of a process with the LHIN, to determine the best use for that money.

**The Chair (Mr. Michael Prue):** Okay, I'm going to have to cut you off there. The next 20 minutes goes to Ms. Gélinas.

**M<sup>me</sup> France Gélinas:** I'm just going to finish what she was getting at. There are 11 of them that receive hospice funding. They don't have residential beds; they provide the care in the community. Some of them that had actual buildings have recently closed.

I guess my question is, how much money do we spend on hospice care right now? Let's start with this.

**Hon. Deborah Matthews:** I'm aware of only one hospice that closed in Toronto. Are there others you're aware of?

**M<sup>me</sup> France Gélinas:** No. I'm aware of that one closing.

**Hon. Deborah Matthews:** Perram House closed, and that money was transferred to another hospice that was operational, that didn't fall under that original funding agreement with hospices. So the Kensington Hospice has received funding that had been directed to Perram House.

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**M<sup>me</sup> France Gélinas:** How much money do we spend altogether on hospices?

**Hon. Deborah Matthews:** We will get you that number.

**M<sup>me</sup> France Gélinas:** Okay. Can I have it broken down and—

**Mr. Saäd Rafi:** Sure.

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



**M<sup>me</sup> France Gélinas:** Okay, into as small chunks as you can. Their funding comes through the LHIN, so I guess I could get it at the LHIN level.

**Hon. Deborah Matthews:** Yes, you could.

**M<sup>me</sup> France Gélinas:** Do you still keep track of physician distribution and identify underserved communities?

**Hon. Deborah Matthews:** We do not have the Underserved Area Program any longer. We've replaced that with the NRRR, which is having a wonderful impact in northern and rural Ontario.

Do we still keep the data? I will have to—

**Mr. Saäd Rafi:** I don't know how much detailed data we keep, but we certainly are trying to monitor the needs through HealthForceOntario, especially in certain rural communities, EDs etc.

**Hon. Deborah Matthews:** The LHINs now have responsibility for primary care. They have primary care leads in each of the LHINs, and it is very much a focus of the LHINs to make sure that everybody can get access to a primary care provider. We don't dictate where doctors set up practice, so we are a little bit limited in what we can do, but the LHINs are taking on that—

**Mr. Saäd Rafi:** The ICES study—

**Hon. Deborah Matthews:** ICES—go ahead.

**Mr. Saäd Rafi:** There's an ICES, the Institute for Clinical Evaluative Sciences, study on primary care coverage in Ontario by distance. It looks at the entire province as to the supply of primary care physicians. We could provide you with that as well.

**M<sup>me</sup> France Gélinas:** Okay. So right now, the ministry has no overall responsibility to manage that precious resource we call physician manpower. All of this is being done at the local level, yet the LHINs don't fund physicians?

**Hon. Deborah Matthews:** We have some tools. We have family health teams, we have community health centres, we have nurse-practitioner-led clinics, where we do determine physically where they are located. But physicians are not employees of the government. We pay them to provide care.

The LHINs, though, are very much interested in the distribution of physicians. It's fair to say that because we now have, I believe, 4,000—maybe even more; 5,000—more doctors working in the province, they're going where they can get patients. I'm sure that when you met with the OMA students, you heard that their number one concern was, "Will we have a job when we graduate?" So we are addressing the shortage of physicians. We have some communities where physicians are having trouble getting enough patients to make their practice viable, and, as we do more of that, then they are moving to other communities.

**Mr. Saäd Rafi:** I would just add that we have the only 25-year study of physician and nurse supply in the country. The deans of medicine from across the country are using that in a committee that has been struck with ministries and deputy ministers of health to try to do a

better job to look at that supply, because it takes about 10 years to grow a physician in terms of a specialty.

Secondly, as you would be well aware, I think the investment in NOSM, the Northern Ontario School of Medicine, has shown a percentage in the 90s of graduates who stay in the north, who end up being attracted to study at NOSM, and they're also coming from the north. I think those are a couple of measures that, while they may not be systemic planning, are certainly indicators of an understanding of where supply could be matched with need, recognizing that the run rate is a long cycle, and to get that balanced perfectly is really difficult.

**M<sup>me</sup> France Gélinas:** You've mentioned the family health teams. I'm interested in knowing how much the government invests in family health teams altogether. If you can break that down in any way you can share it with me, I would appreciate it. As well, you also fund FHTs position-specific, so I would like to have a breakdown as to how many different positions you fund through the family health teams, as in how many physicians, how many nurse practitioners, how many nurses, how many social workers?

**Mr. Saäd Rafi:** We fund the inter-professional service providers. We don't necessarily fund the physicians; they are billing through a capitated model or through fee-for-service. But, yes, I think we can do that. There are 250 family health teams, so it will take a bit of work.

*Interjection.*

**Mr. Saäd Rafi:** Two hundred. Sorry.

**Hon. Deborah Matthews:** Two hundred.

We have 1,800 allied health professionals, I think it was, working in our family health teams, and over 2,000 physicians, if my memory serves me right. We add 40 net new physicians every month to our family health teams. So while we have 200 teams, they are growing and serving more and more people.

**M<sup>me</sup> France Gélinas:** So this is what I'm interested in: the 2,000 physicians and the 40 new ones every month. Where are those numbers captured, as in you can tell me you fund directly 1,800 allied health, and I take it you will give me a breakdown if they are nurse practitioners, physiotherapists or others, but when it comes to the 2,000 physicians, how do we know who works in the family health teams? Are they all GPs? Are they psychiatrists? Are they—what do we know about them?

**Mr. Saäd Rafi:** They would be very unique to the catchment area they serve, as would the allied health professionals in terms of how many PTs would be needed versus NPs etc. That is based on an application approach where the family health team organization says, "We can roster X number of patients over this period of time, ramped up." So there's a back-and-forth with them.

Many times they might be more ambitious, so we might give them X per cent in the first year and then monitor it year by year to see whether they are hitting their roster targets. So it's not formulaic per se. It's really quite dependent on catchment and need.

**M<sup>me</sup> France Gélinas:** Because when the Auditor General did a review of alternate payment plans, he made

it clear that family health teams went what is described as the healthy and the wealthy. They did not go in areas of the province that had the highest needs. They went into areas of the province where people were wealthy, where people were healthy.

Now you're telling me that we are adding resources to areas of the province that are already healthy and wealthy, but yet there is no mechanism to see how the distribution is being done, to manage physicians' manpower so that accessibility for people who have the highest need is done. It's not going to happen through the 200 family health teams that are in place. The auditor has already told us that they had located in areas of healthy and wealthy Ontarians.

**Hon. Deborah Matthews:** So, never wanting to quarrel with the Auditor General, I think it would be time for a refresh of that perception. And, of course, community health centres, as you know better than anyone, are by and large—not exclusively, but by and large—located in communities that are harder to serve.

**M<sup>me</sup> France Gélinas:** They're not getting 40 new physicians every month, are they?

**Mr. Saäd Rafi:** That's the number of physicians entering practice in the province, as opposed to all primary care physicians going into family health teams. So I think we want to be careful about—it's about 2,700 physicians as of September, up 300—

**Hon. Deborah Matthews:** In family health teams?

**Mr. Saäd Rafi:** Yes. That's up from 2,400, which I think was a question last year. So that would stand to reason, that some 180 physicians are entering practice in differing ways, and that ratio probably works, given the number of family physicians to overall physicians in Ontario.

**M<sup>me</sup> France Gélinas:** Okay. What Minister Matthews had told me, I thought was true. From the ground up, you are adding physicians to family health teams at a steady rate. That's what they—

**Mr. Saäd Rafi:** Rosters are increasing as well, and when they hit certain roster numbers, then it may be necessary to add a physician to a practice. But we try to temper that based on the demonstration that that family health team has hit its roster numbers, and some don't.

**M<sup>me</sup> France Gélinas:** And what happens to other models of care? What happens to community health centres, aboriginal health access centres, nurse-practitioner-led clinics that do reach their rosters? How come they don't have access to growth? They tend to be located in areas of high needs, but when they hit their roster—and it doesn't matter how long the wait-list of people who want to go see them—they don't get extra resources. But the family health teams, who in the opinion of the Auditor General are located in the healthy and wealthy neighbourhoods, do.

1700

**Hon. Deborah Matthews:** You know that we've almost doubled the number of community health centres. We have invested significantly in expansion through community health centres. The nurse-practitioner-led

clinics are doing well but they've still got room to grow within the existing models. So we do watch carefully how many patients they're rostering. We do enhance capacity where there's a demonstrated need.

**M<sup>me</sup> France Gélinas:** Okay, I'll focus, just for this one, on aboriginal health access centres. Let's start with, how much money does Ontario invest in aboriginal health access centres?

**Hon. Deborah Matthews:** We'll get you the number. I don't have it offhand.

**M<sup>me</sup> France Gélinas:** And what is the process in place for them if they have long, long wait-lists of people who want to become their patients? What are the processes in place to increase their staffing?

**Hon. Deborah Matthews:** We'll get you the answer on that. As you know, I think there are only maybe 12 or 15 AHACs?

**Mr. Saäd Rafi:** Twelve, I think.

**Hon. Deborah Matthews:** Twelve, yes. So, they—  
*Interjection.*

**Hon. Deborah Matthews:** Ten? Okay, 10.

Then we have some others, like the Anishnawbe here in Toronto that is not an AHAC. So we have a number of these practices that focus on aboriginal health. We've got a nurse-practitioner-led clinic in Thunder Bay that focuses on aboriginal health. The issue of health equity, particularly amongst the aboriginal people, is something where we're doing as much as we can to have much, much better improved services for aboriginal people, even though we'd like the federal government to be more of a partner on that front.

**M<sup>me</sup> France Gélinas:** I agree there. What I would ask, then, is: Since last year, how much more resources were invested into family health teams, how much more resources were invested in AHACs, in community health centres and in nurse-practitioner-led clinics, which are the four—

**Hon. Deborah Matthews:** Models.

**M<sup>me</sup> France Gélinas:** —models. If you could supply this, please?

Then, I'm interested in the new birthing centres. When will they be operational?

**Hon. Deborah Matthews:** The one in Ottawa is now operational. I was there for the opening of it. It's lovely. The Toronto one ran into some other development issues, and I think they are scheduled to open in the next few months—it's well on its way, but I don't believe it's open yet.

**M<sup>me</sup> France Gélinas:** And how much money did the ministry invest in those two birthing centres for the last fiscal year, as well as, how much do you intend to invest into those two?

**Hon. Deborah Matthews:** There will be the capital costs to get them built and then the ongoing operation of them.

**M<sup>me</sup> France Gélinas:** I'm more interested in the ongoing operational costs. How much have we invested in the operational costs so far in the last fiscal years?

How much do you intend to invest in them once they're fully operational?

**Hon. Deborah Matthews:** Excluding fees to midwives?

**M<sup>me</sup> France Gélinas:** I'd like both.

**Hon. Deborah Matthews:** Midwives bill on a fee-for-service.

**M<sup>me</sup> France Gélinas:** No, they're on salaries.

**Hon. Deborah Matthews:** No, course of care.

**M<sup>me</sup> France Gélinas:** Course of care, okay.

**Hon. Deborah Matthews:** So that's a capitation fee, yes.

**Mr. Saäd Rafi:** It's going to be a small number.

**M<sup>me</sup> France Gélinas:** Yes, but I'd still like to know the number.

**Mr. Saäd Rafi:** Just to temper your expectations.

**M<sup>me</sup> France Gélinas:** Small numbers are good, too.

**Mr. Saäd Rafi:** Okay. I just didn't think you were leading to small numbers; you were looking for bigger numbers. The comparison will be very stark.

**M<sup>me</sup> France Gélinas:** I realize it's only two birthing centres.

**Mr. Saäd Rafi:** One, because one hasn't opened yet, and the other one just opened, so its operational costs will be very limited in a partial fiscal year.

**M<sup>me</sup> France Gélinas:** Then I'm more interested as to, how much money did you put aside to run those two, once they're at full capacity?

**Hon. Deborah Matthews:** Yes.

**Mr. Saäd Rafi:** Okay.

**M<sup>me</sup> France Gélinas:** I continue to receive complaints about ambulance fees, where people have to pay when the ambulance came and picked them up. Has your ministry looked at this at all? Do you know who are the highest billers and the smallest? Do you have any intention of putting out any regulations toward ambulance fees?

**Hon. Deborah Matthews:** Are you talking about ambulances or are you talking about stretcher transport services?

**M<sup>me</sup> France Gélinas:** I always like this when new vocabulary comes into place.

**Hon. Deborah Matthews:** The stretcher transport services are not ambulances. They are not manned by paramedics. They are used to transport people who need to be on a stretcher but who are stable.

**M<sup>me</sup> France Gélinas:** Okay. Let's start with ambulances. I dial 911; I'm not feeling too good. I call an ambulance; they come to my house; I get to the hospital. Depending on which one happens to come and pick you up, in my riding, you will get a bill between \$75 and \$95 coming to your house.

**Hon. Deborah Matthews:** I believe the fees are consistent across the province. I'm pretty sure that seniors and people on disability are not charged for those services. We'll get you the policy on that. The stretcher transport services are different, though.

**M<sup>me</sup> France Gélinas:** Is this what I know as inter-facility transport?

**Hon. Deborah Matthews:** Yes, probably.

**M<sup>me</sup> France Gélinas:** They're now called stretcher transport. And who regulates those?

**Hon. Deborah Matthews:** They are currently not regulated, but the Ombudsman has recommended that we do, and we are very close to the point where we're going to be able to regulate them. It's the Ministry of Transportation and the Ministry of Health working together. We've been in consultations with the sector, and that will be coming forward shortly.

**M<sup>me</sup> France Gélinas:** Are we measuring "shortly" in hours, days, weeks, years, or decades?

**Hon. Deborah Matthews:** Definitely not decades, nor years.

**M<sup>me</sup> France Gélinas:** Okay. Months?

**Hon. Deborah Matthews:** Maybe.

**M<sup>me</sup> France Gélinas:** All right. Okay, same thing about parking fees: I'm sure you receive those unhappy campers' emails about parking fees that are real barriers to access for a number of people. Any intention, from the ministry perspective, to put an equity lens, an access lens, onto the issue of hospital parking fees?

**Hon. Deborah Matthews:** I'm sure you know that each hospital is an independent corporation that makes decisions around charging for parking. I get the same letters that you probably get. I think that each hospital board should have a very serious look at the fees they charge.

Some hospitals provide passes for people who come regularly for dialysis, for example; they could pay less. People who have a loved one in hospital for an extended period of time could get a reduced fee. So this is—

**M<sup>me</sup> France Gélinas:** Sorry. Some get it almost right; some, frankly, don't. To say this is what you would like to see—you are the Minister of Health. There are enough people who have put in enough complaints about this that, at this point, I think the sector needs to be regulated. To leave it to individual hospital boards, which is the way that it has been for such a long time, has caused serious barriers to access for a lot of Ontarians.

**Hon. Deborah Matthews:** I will take that under advisement. Of course, you know that patients will say that's one of the reasons they like community-based clinics. Because they aren't located in the hospital, not only do they not have to pay for parking but they don't have to walk so far, once they park their car, to get to the part of the hospital where they'll receive their care.

In London now, we've got a dialysis centre that's located on the second floor of a mall. Patients love it because they can just park, and it's a much more pleasant experience than the experience they had before, when they had to navigate the hospital.

This is an issue—I'll be honest with you—that troubles me, and I take your advice.

**The Chair (Mr. Michael Prue):** All right. I'm going to have to stop you there. You went about 30 seconds over.

We're now on to the government. Ms. Jaczek, the floor is yours.

**Ms. Helena Jaczek:** Thank you, Minister. Thank you, Deputy. I was impressed by your perspicacity, Chair. In fact, my first request of the minister would be to continue her slide presentation on Transformation in Motion.

**Hon. Deborah Matthews:** Okay.

**The Chair (Mr. Michael Prue):** And I'm impressed by the word. I have not heard that, "perspicacity," for a long time—clearness of thought, by the way.

**Hon. Deborah Matthews:** Clearness of thought? Excellent.

I think I was on slide 36, which deals with health links. I have to say that for me, health links are the most exciting thing happening in health care right now, because they really do put the providers together with the patients to be creative, to be thoughtful, to be responsive to patients' needs. We now have community health links in 37 different communities. We see the day where everyone in the province will have access to a health link.

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What we're saying to these health links is, "Here's a patient with complex needs. Don't point the finger at us or at each other. Figure out the problem that works best for this patient."

We have an associate deputy minister, Helen Angus, who is responsible for transformation. She has been leading the charge on health links, and we're seeing wonderful results from health links, getting people out of hospital and into the most appropriate care in a much more coordinated way.

When it comes to information-sharing, 10,000 physicians and nurse practitioners have a provincially funded electronic medical record or are in the process of implementing it, so nine million of the 13 million Ontarians have an electronic medical record.

The mental health strategy is supporting collaboration. As I said, we focused on children initially, but the focus increasingly will be on adults.

We did also put a significant investment into our narcotics strategy to support people with addictions to prescription drugs, particularly.

These health links—we've talked about them a bit. It's all about wrapping the care around individuals so that if they are receiving care from different providers or if they are transitioning between different parts of our health care system, the team is there around them. I'm very excited about this opportunity and I'm inspired by the front-line providers who are recognizing and acting on the opportunity to work together.

We've got 37 health links. We've got lead partners. Each one selects their lead partner. We've got community health centres, family health teams, hospitals, CCACs and community service organizations, all working together. As these community health links are getting more established, they are learning that they need to go beyond traditional health providers, so they are including mental health agencies, public health units, food banks, EMS, educational providers, housing, police, long-term care. It's geographically defined—about 100,000 people, typ-

ically, is the population of a health link area—and it's working beautifully.

What it means for patients is that they will have common principles for coordinated care plans. Patients will have help navigating the system. We are determined to let the patients guide their care plan. As I say, it's working well.

Bernice, on slide 40, is actually a real person. She's 64 years old. She has multiple medical and mental health issues, including diabetes. She lives alone in subsidized housing and receives social assistance. She has no transportation available. She often misses appointments. Because she can't get the care she needs, she can't make it to the appointments, her care is uncoordinated. She is suffering. Her cost to the health care system was about \$90,000 for that year and she was not getting the care that she needed. With the help of a community health link, we get all the right people providing the right care, wrapping that care around her. So we are starting to see stories of people who are benefiting from community health links.

As I say, our objective is to cover the province. I will just talk about a couple of examples of progress.

The mid-Toronto west health link has 70 physicians, attendant sector engagement. We have patient engagement strategies for seniors, Chinese, young adults, and complex vulnerable subpopulations. We've got rural health links that are providing a range of care and measuring the success. So we are measuring progress.

We are looking at reducing avoidable emergency department visits, reducing unnecessary 30-day readmission to hospital, reducing the time for referral from the primary care doctor to the specialist and improving the patients' experience in their journey through health care.

As I say, we had remarkable response from health providers across the province. We now have more than 37—more in the works—and I am, as I say, very excited about this. This is unlike anything else we've done in the ministry, because we are really letting go. We are letting those professionals who know their communities and know their patients guide health links. They are working with the LHINs, and our approach is flexible. We are placing our confidence in the front lines. We believe they know their patients best, so our job is to break down the silos and facilitate them in providing the best possible care.

I call Helen Angus our silo buster, because her job is to make the system work for patients with complex needs. You'll see this quote on slide 45. Dr. David Price is a real leader in primary health care in this province. As you can see, he says, "All of those involved have experienced important epiphanies, the 'stuff' of which transformation is made...." We're finding that these providers are having those "aha" moments where they just realize that a little bit of extra—maybe it's transportation to appointments—really changes the outcome for patients.

We knew that sometimes our policies and our procedures were impeding innovation and transforma-

tion, so we have said to the communities, “You tell us what we need to do differently.” Just one example is that some physicians and nurse practitioners have difficulty accessing mobile X-ray services in long-term-care homes, so some residents are sent to hospital for X-rays when they could get mobile X-rays in the long-term-care home. So, again, better value for money, better care for patients.

We are moving forward with health links and with transformation, so we really are wanting to create systems that allow health care providers to spend more time with patients. We’re expecting greater shared accountability for the patient journey. A lot of work is under way with quality improvement plans, not just for hospitals, but for providers—more is needed. We have an ongoing quest for the evidence about best care and what interventions have the best, most significant outcome for patients. We are striving to be transparent, and we need a financially sustainable health care system.

The indicators of success outline how we know we’re achieving the results we need for transformation, including that wait time one, from referral—when the primary care refers the patient to the specialist—to the time they see the specialist; 30-day readmissions, avoidable ERs, so there is a range of ways that we are measuring our success.

We are really looking to the sector to provide local solutions. Much as we would like to run everything from the 10th floor of the Hepburn Block, we actually know that others can do it better, and the people who can do it better are the people on the front lines.

We’ve got a website. It’s got information about the action plan. There’s a collaborative space for health links to connect with each other, blogs chat rooms etc., and we’re wanting to make sure that patients know what’s available to them so that we do have a sustainable health care system.

**Ms. Helena Jaczek:** Thank you, Minister.

**The Chair (Mr. Michael Prue):** The floor is still yours.

**Ms. Helena Jaczek:** Thank you.

Well, it’s useful to think of the action plan as having these four pillars, and I’d like to explore a little bit more on the funding reform piece. Specifically, the attempt is to hold the line on hospital budgets and to shift resources wherever possible. Perhaps you could just talk a little bit about how hospitals are coping with this, the type of response you’re getting from, obviously, very important stakeholders and how you see progress being made in terms of increasing that community care piece?

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**Hon. Deborah Matthews:** When it comes to the hospital funding transformation, I cannot stress enough how big a challenge this is for hospitals. They are working very hard to wrap their heads around what the future looks like for those hospitals. Of course, some hospitals, particularly hospitals in growing communities, want us to do this fast. They want it tomorrow. Other communities where the population is not growing are seeing a small

reduction in funding, so they need to rethink how they deliver care.

What we’ve done is—our model does show what hospital funding would be at full implementation, but we’re doing that over a number of years. So we put what we call mitigation corridors around the changes. Last year, I believe no hospital received less than negative 2% and no hospital received more than a 2% increase, so it was a plus 2, minus 2 corridor. This year it’s a minus 1, plus 3 corridor. We are doing this in a manageable way, but hospitals know what’s coming and they are working hard to adjust to their new reality.

I can tell you that I have been enormously impressed with hospitals and with the Ontario Hospital Association. They all know this is the right way to go, but getting from here to there is difficult. They are doing that work, and I would say it’s going well—in fact, I would say it’s going very well—but it is not easy work for hospitals. They’re having to make difficult decisions, but they’re rising to the occasion.

The movement to the community is going very well. We’re seeing our ALC, alternate level of care, rate drop—people who are in hospital who shouldn’t be in hospital and would receive better care elsewhere. We’ve seen it drop by 25%, and I think we’ll continue to see progress on that as more and more hospitals embrace the Home First philosophy.

I had a personal experience recently where a gentleman I know—he was in his 80s—had a stroke and went into hospital. The hospital said, “It’s time for you to go into long-term care.” He said, “Over my dead body.” So they applied the Home First philosophy. He did go home. He was home for another year, which was exactly where he wanted to be, and he eventually passed away. He had another stroke and passed away, but he never did have to go into long-term care. That, for me, is a real success story. We’re enhancing those home supports. He got home from hospital; he didn’t have to go into long-term care. So it’s working.

When I first became health minister and I was trying to wrap my head around this ALC issue—I knew it was the most expensive care, and I knew it wasn’t the highest quality of care—the answer became quickly apparent. We could free up those hospital beds for people who needed to be in them, free up those hospital beds for people in ER—we are seeing a reduction in ER wait times because those beds are available—by shifting resources to the community.

So while hospitals are having to make these significant changes to how they operate, we are also taking pressure off them by investing elsewhere in the community. They know that, they recognize it and they are very supportive of it.

**Ms. Helena Jaczek:** As you know, Minister, I come from one of those very high-growth areas of the province, and I’ve certainly heard from some of my constituents, knowing that hospital budgets are constrained to a certain extent and that we’re shifting to the community—there’s a fear sometimes that hospitals are going to dis-

charge patients prematurely, just to sort of manage in terms of the patient load that is constantly coming in through the emergency department. So I was wondering: How is the LHIN or how are we monitoring this type of potential problem of early discharge? Are we looking at readmission rates? Who is really responsible for making sure that that type of fear is not realized?

**Hon. Deborah Matthews:** The decision to discharge a patient from a hospital is a clinical decision, and it's very important that physicians—and I think they do know that that is a clinical decision that they would make only in the best interests of that patient.

We are hearing, anecdotally, about physicians who are more comfortable discharging patients when they know there is very robust home care support that will be there for them on discharge. When people are ready to go home, getting them home with the right supports actually can reduce the length of stay in a hospital.

We do measure readmission rates. A 30-day readmission rate is a very good, internationally acknowledged indicator of that transition home. If there is a good transition home, then people won't come back very often. If there was not a good transition home, whether they aren't taking the medications as prescribed or they didn't get home care, we will see them come back to the hospital. So that is, I think, one very good indicator of that part of the health care journey.

**Mr. Saïd Rafi:** I would just add that we're also looking at the opposite side of the issue, which is a higher degree of admitting rate for patients because they might be easier to care for. In the quality-based procedures where expert panels are examining this, we're now moving to look at appropriateness and length of stay so that there will be an ability to track and monitor and to say that, "You're admitting 40% of minor stroke patients when the length-of-stay best practice is 15%"—or knee-replacement rehabilitation, in-patient versus out-patient. So we're trying to use evidence on both ends of the spectrum.

**Ms. Helena Jaczek:** Thank you very much.

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

**Ms. Helena Jaczek:** I wanted to talk a little bit more about home care in terms of that investment. Just broadly, what type of percentage increase have we seen recently?

**Hon. Deborah Matthews:** Last year our budget was 4% to the home and community care budget; this year it was 6%, because we know that it is a key enabler of transformation. The more we invest in home care, the more we can get people home safely and quickly.

**The Chair (Mr. Michael Prue):** Thank you. We now have 20 minutes in rotation to the Conservatives. Mr. Clark.

**Mr. Steve Clark:** Thank you very much, Chair. Minister, earlier in questioning by Ms. Elliott you had mentioned long-term-care homes in a discussion about the CMHC. I understand that there are some opportunities for prepayment for long-term-care homes with CMHC mortgages that require capital repair or renos. Are you aware of those, that that's an issue in some long-

term-care homes? Because you're going to be having conversations with the CMHC, I just wondered what your list of items were.

**Mr. Saïd Rafi:** I'm not familiar with the prepayment opportunity, but I think that the CMHC has made a national decision to be out of long-term-care-home funding. It has apparently affected some home providers. This is the feedback we got in part of the market testing.

We've engaged with CMHC, and they have put a number of requirements that they would like to see—transferability of the licence and their taking on of the licence should a default take place, I believe. So we're working through those with them. They're looking to have all their conditions met before they wish to re-enter the market, but we're still trying to encourage that. I would have to look into the prepayment opportunity.

**Hon. Deborah Matthews:** The way we fund long-term care, as I'm sure you know, is that we don't pay up front; we pay on a per diem. Those long-term homes do have to get that financing over a period of many, many years, and they will get it back over time through enhanced per diem payments.

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**Mr. Steve Clark:** Yes, and the reason that it twigged my mind when Ms. Elliott was asking the question is that I have a home in my riding, just outside of Brockville in Elizabethtown-Kitley, Sherwood Park Manor, and they're having a particularly difficult future, partially because of their 50-year CMHC mortgage.

**Hon. Deborah Matthews:** On their existing building?

**Mr. Steve Clark:** Yes, on their existing building.

**Hon. Deborah Matthews:** They have a 50-year mortgage?

**Mr. Steve Clark:** Yes. It goes back from the 1970s. We've been going back and forth with my MP, and I saw a letter from Minister Finley that indicated that the mortgage was transferred to the province back in 1999. So there's this discussion about how—because it's a not-for-profit home, and I'm sure you know that in the South East LHIN, they're a bit of an anomaly. There are only three not-for-profit, non-municipal homes within the South East LHIN, and Sherwood Park Manor is one of them. I've had some time to think as we've had the rotations, and I'm wondering if the ministry would consider working with a home to provide funding to allow them to renegotiate a mortgage that is now a constraint for them to operate. It's one of the many constraints.

**Hon. Deborah Matthews:** I will definitely undertake to look at that particular situation. I don't know what options we might have, but we will definitely look at that.

**Mr. Steve Clark:** Yes, and the other thing I understand is it becomes a prepayment penalty. So let's say the home decides they're going to prepay it and get a better rate, to get a market rate today. I guess because of the federal-provincial relationship, perhaps—and you may want to comment or may want to reserve comment. I would love to see the ministry perhaps help lobby CMHC to have a more favourable penalty so it's not a constraint

on the home to try to renegotiate and get themselves back on a financial footing. That would be something that I would think you would want to do in your conversations with CMHC, and ask specifically about that prepayment penalty that I understand is a huge issue.

**Mr. Saäd Rafi:** We'll look into the specific situation of the home, and if there are penalties for prepayment, I would agree, and maybe there's something we can speak to CMHC about.

**Mr. Steve Clark:** Yes, and the other thing that I think perhaps you could ask the LHINs province-wide is, "Has this come up? Have other long-term-care homes approached their local LHIN or the ministry about these CMHC mortgages, asking for some assistance?"

**Hon. Deborah Matthews:** It's the first I've heard of it.

**Mr. Steve Clark:** So that would be an interesting question to pose. I'd love to have that answer—and not just the number. I think if there was some assistance that the ministry or the LHINs did give the home, I would love, again, to get that type of information back. It would be, I think, quite useful.

**Hon. Deborah Matthews:** We are very committed to the redevelopment, so if this offers another opportunity—

**Mr. Steve Clark:** Sure. Listen, I'm going to be totally honest with you: There are 107 long-term-care beds in my riding, and I don't want to lose them. I want them to remain in Leeds–Grenville. I don't want them to move, and I recognize that they don't have the same funding opportunity as the home across the street, the municipal home that has a municipal contribution. I guess my concern has always been that these types of homes, this anomaly of a not-for-profit home with no municipal agreement—they don't have the opportunity to get supplemental funding. With a municipality, you would go to the board and you would deal with the municipality directly. I think it would be something that the ministry would want to look at, given the fact that there are so few strictly not-for-profit homes in the province.

Again, it twigg'd my mind when you talked about the not-for-profit clinics. Again, this is something that's very narrow. There are not a lot of them around, so I would hope that you would look at that and just put that on your radar screen.

**Mr. Saäd Rafi:** The question about what other long-term-care homes have asked for assistance regarding CMHC—interestingly enough, Revera, a publicly traded company that has Canadian and US operations, has asked for some assistance with CMHC because they exited the market, CMHC did. I guess the financing is a little cheaper, whereas other foreign not-for-profits seem to be using other mortgage insurance providers.

**Mr. Steve Clark:** Just on another subject I'd love to hear your comments on: I received a document in my inbox, and they say that every MPP got one from a group called OCLR, the Ontario Coalition for Lab Reform. It was a press release dated October 28, and they talked about a report called *Bad Labs in Ontario: Waiting Too*

*Long.* Are you aware of this press release and this website regarding bad labs?

**Hon. Deborah Matthews:** I am definitely familiar with the Ontario Coalition for Lab Reform. I think Gerard Kennedy is the president of that organization.

**Mr. Steve Clark:** Yes, I'm just reading that.

**Hon. Deborah Matthews:** I'm not familiar with that particular report, but what I can tell you is that we have a review of our lab services under way right now, and it's good to see one particular lab or the coalition of labs weighing in on what needs to be done in that sector.

I can tell you that the highest priority for me is access, that people who need to get their blood tested or whatever have reasonable access to those specimen collection centres, that they are of the highest quality, that we have confidence in the results and that we get the best value for the money we spend on labs.

This is a part of our health care system. I think it's fair to say there's not much in the health care system that we're not looking at pretty closely, and the lab sector is one of them.

**Mr. Steve Clark:** The release I've got in my hand says, "The coalition presented its reform plan for a new 'patient choice' system that would compel community labs to compete with one another to provide patients with better service, lets the Ministry of Health get best value from an updated pricing system and set up stronger provincial oversight and standards, at a savings to government."

Have you included that type of patient choice system as part of your review? Are you looking at that model?

**Hon. Deborah Matthews:** Sure. Labs are private companies or publicly traded companies. They are companies that compete. We are looking at the fee schedule, because we do know that technology has improved productivity in the lab sector as well, so that's one of the things that we are reviewing in this lab review.

**Mr. Steve Clark:** And when did you say that the review would be finished and the results would be made public?

**Hon. Deborah Matthews:** That work is under way.

**Mr. Saäd Rafi:** The challenge that sometimes isn't put out in the limited space that releases may provide would be that we have 60% of tests from one provider, 30% from another, and then three or four plus companies that make up the difference. Choice is always very important, and that speaks to, perhaps, access.

Quality is also important, like the minister said, and value for money, which that release identifies as well. It's a big province, so geographic dispersion of access points has to be taken into consideration. We're finding that it's a very challenging move to go from an existing structure that has been in place since, I believe, 1996 or 1998 to instant full competition without having winners and losers. We want to take our time to do that and not create a situation where bigger players are advantaged or smaller players are advantaged or disadvantaged, so I don't have a detailed timeline as to when we might get that.

**Mr. Steve Clark:** Are you looking, as well—I know some of the docs in my riding mentioned this before the last election—at allowing hospitals or family health teams to create proposals and jump in the mix in a competitive system? Is that also part of your review?

**Mr. Saäd Rafi:** It is, and we did consult with the hospital community, the Ontario Hospital Association, because hospital lab volumes are almost as high as these community lab volumes—you know, back and forth. The nature of hospital lab testing is somewhat different—emergent need, as opposed to planned or scheduled, like you might get from a requisition from a family physician. But, again, are there some things that hospital labs could do, or are there some things that community labs could do for hospitals? Again, is that a better price point with value as well?

We also looked at public health labs. On that, we decided that the province-wide nature of a public health lab, as it deals with international labs, didn't fit that model. We continue to look at all sources that are providing millions of lab tests a year.

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**Mr. Steve Clark:** I'm not very good at some of these diseases, so I'm going to spell this one first for you. Just for Hansard's benefit, right?

**Hon. Deborah Matthews:** Yes.

**Mr. Steve Clark:** A-d-r-e-n-o-l-e-u-k-o-d-y-s-t-r-o-p-h-y, or ALD. I have a young constituent, Sam Tobias, who passed away April 5. He was eight years old.

**Hon. Deborah Matthews:** Eight years old?

**Mr. Steve Clark:** Yes. It was a disease that his parents, Nicole and Craig, tell me that you can treat if it's caught in a newborn screening. They've also indicated to my office that because we're a border community—New York state is right across the south end of my riding. They're telling me that New York state is doing newborn screenings and that other jurisdictions are looking at it as well.

I'd be interested to know the cost of such screenings and what they would be if the government made a decision to screen newborns and try to understand how to balance that cost in terms of people who are affected by ALD. So I'm not sure if you want to say a comment or—

**Hon. Deborah Matthews:** I'm more than happy to speak to newborn screening because this is something where Ontario has made big investments.

Ten years ago, we screened for two conditions; now we screen for 29. I just announced the most recent screen that all newborn babies in the province will get, and that's for bubble boy disease. It's called SCID, severe combined immunodeficiency syndrome.

At the last federal-provincial-territorial meeting, the health ministers agreed that we would look at a pan-Canadian newborn screening protocol, because when you look at what different provinces do, there's a lot of variation. At CHEO in Ottawa, that's where the lab is for the newborn screening here in Ontario, and I actually had a visit to see.

I'm not familiar with this particular condition, but we are looking to continue to enhance newborn screening.

**Mr. Steve Clark:** So you could give me some costing of how much screening for ALD would be?

**Hon. Deborah Matthews:** I could see if we have that. I'm not sure we've looked into that particular screening. I know that screening for SCID was, I think, \$6 a baby. So it's a relatively small cost. And with SCID, it can be treated, if it's caught early, with a bone marrow transplant. It's not a small intervention, but that will save lives.

**Mr. Steve Clark:** Back in November, you and I had a conversation about another issue called EDS, or Ehlers-Danlos syndrome. I had not one but two constituents, a brother and sister, Charlie Smith and his sister Jessica. I know the community did a number of fundraising activities around them. I think most acknowledge that the reason that those fundraising activities took place was the change that the ministry made in out-of-country coverage—the fact that it changed from a GP to a specialist.

We had a long conference call, yourself and I, about being able to access care in Ontario and the frustration that EDS patients had. A number of them ended up going to Maryland to one particular doc for a procedure. I never really closed the loop with you, Minister, about that because I had expected that I'd get some additional information.

I know that EDS is difficult. I think you mentioned at the time that there are a number of different issues around EDS. But again, I would be interested in getting the change in funding from out-of-country coverage prior to your regulation change, when GPs were able to provide that referral, to now the new standard that requires a specialist.

As well, I would like to receive some information from the ministry specifically about health care spending around EDS. You had mentioned to me that there were health care practitioners, specialists, who could provide care for EDS patients. However, when I spoke to the EDS community, I couldn't find any, so I would love to have some treatment figures from you, as part of the estimates process, specifically on EDS. I just see that people are fundraising and that the health care system isn't picking these—in my riding, a young man and a young woman. They've had to go to Maryland for this surgery. I know there have been people in the Speaker's riding where it is the same way, and he and I have had a conversation about this after some initial media attention.

Again, it just speaks to the fact that things have changed, and now I see a lot of community fundraising within my riding and throughout the rural area that I represent and that some of my neighbours represent. It just seems that people are always fundraising for diseases and conditions that they didn't have to fundraise for in the past.

**Hon. Deborah Matthews:** I can give you my assurance that nobody should have to pay to send a loved one out of country if there is no provider here who can perform that service. I know that the change that we



made so that specialists are the only ones who can refer out of country was the right change because a family physician simply would not know what options were available here in Ontario. That was the right change, because only a specialist would know what other treatment options were available.

We are determined to provide out-of-country coverage if it's not available here or if it's not available in a timely way here, but when it is available here, then we can't be sending people out of country for procedures that are available. This particular condition—as I recall it, there are a number of hospitals in the province where this procedure is available.

**Mr. Steve Clark:** Not to be argumentative or challenge you, but I have not ever had any information from any specialist or any patient in Ontario who is part of the community that interacts with Charlie and Jessica who can give me the name of someone who will see you or a hospital that will treat you, other than the one in Maryland. Again, if you have information that you want to share with the EDS community, I would love to see it.

**The Chair (Mr. Michael Prue):** I'll have to leave it at a statement rather than a question. I think it was a statement.

The last approximately 12 minutes today goes to France Gélinas. You would, of course, continue on the next date with any remaining time. The floor is yours.

**M<sup>me</sup> France Gélinas:** Thank you. The next question I wanted to ask was about the breakdown of the funding for the new breastfeeding program initiative that you've announced recently. Will there be money available for lactation consultants? Will it be solely for Telehealth? Is it new money or is it within existing resources?

**Hon. Deborah Matthews:** It's new money. If my memory serves me well, it's \$2.9 million. The Telehealth support is only a part of the funding. We are working with hospitals and other health providers to achieve the World Health Organization's baby-friendly initiative standards, and that does mean access to lactation consultants. I don't have the breakdown of that; I'm pretty sure it's \$2.9 million. We will do our best to break that down even further if that's what you're interested in.

But I have to say, when I made the announcement, Dr. Jack Newman, who is probably the best known in the province, was very, very pleased with this initiative.

**M<sup>me</sup> France Gélinas:** Can I expect that every hospital that does obstetrics would have a lactation consultant or access to one?

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**Hon. Deborah Matthews:** I believe that is part of the baby-friendly initiative standard, but I will confirm that with you.

**M<sup>me</sup> France Gélinas:** Okay. And here again I would like to know how this \$2.9 million will be divided up program-wise as well as geographically, province-wide. I'm always interested in the north's share of the pie.

**Hon. Deborah Matthews:** Okay.

**M<sup>me</sup> France Gélinas:** I know that Christine had asked quite a few questions about wait times for home care that

you answered. The part that I wasn't clear on is that you have told her that in—I forgot my notes—90% of the cases, for nursing it's less than four days and for PSW it was quite a bit longer. Do you start measuring from the time of assessment by CCAC, or do you start measuring by the time of assessment by the primary care provider?

**Hon. Deborah Matthews:** Part of this wait-time approach is getting the metrics right and consistent across the province. The numbers the deputy gave you earlier are province-wide numbers. There is variation from LHIN to LHIN and from CCAC to CCAC. One of the things that we're doing is making sure we have consistent metrics so that we actually can measure on a province-wide basis. The numbers we have now are from assessment to first service.

**M<sup>me</sup> France Gélinas:** But assessment by CCAC provider or assessment by your primary care provider?

**Hon. Deborah Matthews:** By the CCAC.

**M<sup>me</sup> France Gélinas:** Okay. You gave us two of them: nurses and PSWs. Do you have the same statistics for other home care providers, such as physiotherapy, social work or speech pathology? Do you have those statistics for children through the School Support Program that are administered through home care?

**Mr. Saïd Rafi:** I think we can get the former; I don't know if we have the latter. I'll have to find out—for children.

**M<sup>me</sup> France Gélinas:** Okay.

**Hon. Deborah Matthews:** But physiotherapy, we know, is zero in 12 of the 14 LHINs.

**M<sup>me</sup> France Gélinas:** It's not zero in the other two?

**Hon. Deborah Matthews:** It's not zero in the other two.

**M<sup>me</sup> France Gélinas:** I'm interested in knowing where it stands for the other two.

**Hon. Deborah Matthews:** Okay.

**M<sup>me</sup> France Gélinas:** And the same thing with social work and other home care services such as occupational therapy. There again, when you get assessed—I can speak for my riding—it can take three months to get your physiotherapy assessment after you have been told that you need home care physio. The physio from CCAC will take three months before they come in and assess you, and another, I don't know, four months before you see an actual physio show up at your door. If you go from the moment that you were referred to CCAC for physio, the person sitting there will tell you, "It took me seven months before I saw them." That's especially true for occupational therapists. You cannot get—I told you this story before—the PSW to come and help you get into the tub because the PSW says that the tub is not safe. Chances are, you need a grab bar. So she makes a referral to the occupational therapist to come and assess what would be a safe way to transfer. She requests the occupational therapist, who doesn't show up for three months, and then actually gets the assessment of the bathroom done another four months down the road. For those seven months, you never got a bath.

**Hon. Deborah Matthews:** That's not okay.

**M<sup>me</sup> France Gélinas:** Agreed.

**Hon. Deborah Matthews:** That's why we're making enhanced investments in home care and community care. That's why we are, for the first time, starting to measure wait times and getting common metrics for that. When people need a physiotherapist after a hip replacement or knee replacement, they need it now.

**M<sup>me</sup> France Gélinas:** Okay. I'd like to know the wait time for the other professions that work in home care and have them by the 14 different CCACs, because the stats are very different depending on where you live in Ontario.

**Hon. Deborah Matthews:** Yes.

**M<sup>me</sup> France Gélinas:** Something else that Christine had started on but I wanted to finish: We understand your commitment to take services out of hospitals and make them available in the community. In theory, it sounds great. You say that you want the not-for-profits to be handling those services in the community, but the recent change in regulations that went through the Ontario Gazette, which everybody reads before they go to bed—there is nothing in there that would prevent a for-profit structure. Why is it that, in the regulations that were put out, we don't find this commitment to the not-for-profit?

**Hon. Deborah Matthews:** I would have to do some investigation on that.

**M<sup>me</sup> France Gélinas:** Aside from you saying you're committed, where are the documents that show that there won't be for-profits taking up this work that used to be done in the hospital?

**Mr. Saäd Rafi:** You mean a for-profit can set up a not-for-profit entity? Is that what you mean?

**M<sup>me</sup> France Gélinas:** No, I mean a for-profit will be setting up an eye institute doing cataract surgery.

**Mr. Saäd Rafi:** It's not intended to do that, so I'll need to look at that.

**M<sup>me</sup> France Gélinas:** Okay. It's not intended to do this, and I hear you say this—

**Hon. Deborah Matthews:** No. You can find it in the regs.

**M<sup>me</sup> France Gélinas:** —but between what you hear and what's written on paper is what people will bid on the work.

The other thing I wanted to ask is: If a group of physicians get together—we'll say a group of ophthalmologists, two or three—to open up an equivalent of Kensington, would they be considered a not-for-profit?

**Hon. Deborah Matthews:** I just received a note that there will be a policy guide released shortly and we will be clear on the not-for-profit status.

**M<sup>me</sup> France Gélinas:** So why not put it in the regulations rather than the policy guide?

**Mr. Saäd Rafi:** There could be all manner of Byzantine legal reasons why that is the case, but I need to look into that. It wasn't the intent to make it permissive, but I'd have to look at the regulation. We are issuing a lot.

**M<sup>me</sup> France Gélinas:** And the policy guide will be specific to that regulation?

**Hon. Deborah Matthews:** It will be specific to the not-for-profit status.

**M<sup>me</sup> France Gélinas:** Okay. And when will the policy guide come? Shortly?

**Hon. Deborah Matthews:** "Shortly," it says here.

**M<sup>me</sup> France Gélinas:** I love those. Minutes, hours, decades?

**Hon. Deborah Matthews:** I would say, not minutes and not hours.

**M<sup>me</sup> France Gélinas:** Days or weeks or months or years?

**Hon. Deborah Matthews:** Not years.

**M<sup>me</sup> France Gélinas:** Okay. Days or weeks or months—I get to pick one. All right.

You didn't answer my second question. If a group of ophthalmologists get together and decide to open up a cataract surgery to go from the hospital to the community where you don't have to pay for parking, etc., are they considered a not-for-profit?

**Hon. Deborah Matthews:** Groups of physicians are for-profits. In fact, an individual physician often incorporates. In that case, hospitals—there would be some options available outlined in the policy guide about how they could organize themselves.

**M<sup>me</sup> France Gélinas:** Okay. I look forward to seeing that.

I'm going into dental. We'll start with CINOT, Children In Need Of Treatment. How much was actually spent? We have how much was allocated for CINOT for 2012-13 and how much was actually spent. As well, more funding was allocated to CINOT. How much of that new funding was actually spent?

**Hon. Deborah Matthews:** I knew you were going to ask the question, so I—

**M<sup>me</sup> France Gélinas:** You came ready.

*Interjection.*

**Hon. Deborah Matthews:** Oh, you've got the answer right here? Okay. In our Poverty Reduction Strategy, we committed to \$45 million in enhanced dental care for children and youth. Part of that was an expansion to CINOT.

CINOT, not including the expansion, is delivered through public health units. So I'm just talking about the expansion numbers.

**M<sup>me</sup> France Gélinas:** That is part of the \$45-million Poverty Reduction Strategy.

**Hon. Deborah Matthews:** I'm sorry?

**M<sup>me</sup> France Gélinas:** Go ahead.

**Hon. Deborah Matthews:** We allocated—this actually isn't—

*Interjection.*

**Hon. Deborah Matthews:** Here we go. So Healthy Smiles—do you want to talk about both?

**M<sup>me</sup> France Gélinas:** Sure. They were next.

**Hon. Deborah Matthews:** Healthy Smiles Ontario: We allocated, in 2010-11, \$29.5 million, and \$30 million in subsequent years. The actual expenditures have been pretty consistent: \$27.9 million in 2010-11, \$25.8 million

in 2011-12 and \$26.7 million in 2012-13, so a little bit of underspending on Healthy Smiles.

CINOT has been very interesting in that we have seen reduced demand, possibly or probably as a result of Healthy Smiles. What we had hoped would happen was that investing in prevention would reduce the demand on CINOT. It appears to be happening. In 2009-10 we allocated \$13.5 million for the expansion of CINOT and spent \$6.1 million, so we were underspent by \$7.4 million. In 2010-11, we allocated \$10.9 million and spent \$3.9 million—a significant reduction—so \$7 million underspent. In 2011-12, we allocated \$3.9 million and spent \$2.9 million, for an underspend of \$1 million.

I made the commitment, back when I introduced the Poverty Reduction Strategy, to spend \$45 million on enhanced dental care for kids in low-income families. As we're rolling this out, we're seeing that we do have some

excess capacity, so we are looking at what we can do. The \$45-million commitment remains. Now that we're seeing a little more stability in how these dental programs are rolling out, we can look at how we can expand access.

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

We have to adjourn for the day. We have three hours and 56 minutes remaining when we come back tomorrow. When the committee resumes consideration of the estimates of the Ministry of Health and Long-Term Care, the NDP has seven minutes left tomorrow.

Therefore, we adjourn the committee until approximately 3:45 p.m. on Wednesday, October 30, 2013. We stand adjourned.

*The committee adjourned at 1801.*

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