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2nd Session
41st Parliament

Wednesday 25 October 2017

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CONTENTS

Wednesday 25 October 2017

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON ESTIMATES

COMITÉ PERMANENT DES BUDGETS DES DÉPENSES

Wednesday 25 October 2017

Mercredi 25 octobre 2017

The committee met at 1603 in room 151.

MINISTRY OF HEALTH AND LONG-TERM CARE

The Chair (Ms. Cheri DiNovo): Good afternoon. We are going to resume consideration of vote 1401 of the estimates of the Ministry of Health and Long-Term Care. There is a total of 13 hours and 13 minutes remaining.

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

Hon. Eric Hoskins: Not that I'm aware of.

The Chair (Ms. Cheri DiNovo): Okay. When the committee last adjourned, the minister had 15 minutes remaining for his right of reply. Minister.

Hon. Eric Hoskins: Thank you very much. As I was saying, for as long as most of us can remember, patients needed to be in the hospital so that they could be monitored by trained health care professionals. The connection between a health care professional and the patient often was only as long as the connection from the patient's room to the nurses' station. Of course, we know that even today, in serious cases, that proximity in hospitalization and connection remains necessary.

It's no longer true to say that it's necessary in all cases, certainly with developments in technology. We've got ways of stretching that connection from patient to clinician all the way to the patient's home through the use of our advances in digital technology—in fact, many of those advances being made in Ontario innovations. But through those advances in digital technology, patients can remain at home—places where they feel less alone, more connected with their community, more competent, and certainly safer and more fully supported.

For example, take the case of a patient living with COPD, chronic obstructive pulmonary disease. That patient can now have their vital signs measured remotely while they're at home, through the Telehomecare program. So you can imagine that their health care provider will be immediately notified when readings change and become more negative or more precarious.

We even have technology that can monitor whether a patient is getting out of a bed at home, or turning on a tap. Imagine the utility of that if somebody is in a fragile state. If they normally get up at 7 o'clock in the morning, and here it is, 10 or 11 or 12 o'clock or even the next day, and they haven't gotten out of bed, that's likely an important indicator in terms of their state of well-being. The same with turning on a tap: If they normally do that on a regular basis and it hasn't happened for a protracted period of time, that sends an important message.

That's the beauty of technology. It won't, of course, replace health care, but it's becoming, more and more, a positive reinforcement of and supplement to the health care services that are being provided in the province.

Not that long ago, and even in many cases today, we relied or rely on a nurse in the ward to do this sort of work, to make sure that the patient is okay or to monitor their blood pressure or their heart rate or their blood oxygen levels. But now sensors can do that in the home and with the patient. And then, after notification remotely to the clinician, calls and visits can be made to follow up, to make sure that the patient is okay, and to intervene at a much, much earlier stage to provide the necessary supports.

We know that for many patients, being able to stay at home is exactly what they want.

Digital health services can also transform access to care for those people who have trouble getting around, or who have large distances to cross to access the services they need—or even if they're simply busy.

We live in an era of FaceTime and Skype, where a patient in one community can connect with a doctor or a nurse practitioner or other health care professional in another community that may be nearby or may be right across the province, thousands of kilometres away. This means that human resources in one part of Ontario can be helping patients and clients in other parts of the province.

Last year, the Ontario Telemedicine Network facilitated nearly three quarters of a million patient clinical encounters in this province in this way. As a result—and this is the amazing part—patients were able to avoid nearly 284 million kilometres of travel. That's universal health care at work.

Again, it's not always appropriate. That face-to-face, hands-on contact is incredibly important for many health care interactions. But we can all imagine, I think—I know—that there are many cases where there is no difference in terms of outcome and, often, much higher patient satisfaction if those same interactions can take place remotely or through digital means.

That's the kind of thinking we need to continue and augment. We're using the tools that we have, but we're

looking at new opportunities for patients—for example, to book their appointments online. It frankly is amazing to think that in this day and age—and there are many exceptions—there are forward-looking practices and health care professionals that do enable that. We can book a reservation at our favourite restaurant online. Why can't we do the same for our health care provider?

We're exploring new opportunities for e-prescriptions, which is important. Present company excepted, who write elegantly—but it's important just in terms of the accuracy of the prescription, so that the pharmacist knows perfectly what that prescription calls for and doesn't have to decipher a physician's handwriting, which—

Dr. Bob Bell: Minister, I just want to be clear that orthopaedic surgeons never write prescriptions.

1610

Hon. Eric Hoskins: Noted.

With e-prescriptions, it will not only provide greater safety, security and accuracy, which results in better safety and better outcomes and results for the patient; it is a tool which will be useful for everyone participating, from health care provider down to the pharmacist, down to the patient.

We anticipate, as well, that e-referrals will streamline and shorten wait times. We've already piloted e-referrals in one LHIN; we're expanding it in to nine LHINs in the province. And e-consultations speed the pace of referrals. Again, you may have a patient with a skin rash. If you're in some parts of the province, you can take, as a practitioner, a photograph of that arm with the rash, send it securely to a dermatologist who is waiting to respond to the consults that come before her or him, perhaps add a little bit of narrative in terms of the history of the patient, and very quickly, certainly a lot more quickly than having to wait two or three or four weeks—or even months, often—to see a dermatologist, you can actually have a diagnosis and a treatment plan back through the family doctor or nurse practitioner very quickly. Imagine what that means in terms of patient satisfaction—not having to find the time for that consult down the road, but the time you have to wait and the physical and mental aggravation that can happen in the interim.

Much of the technology we already have today allows us to perform these tasks for us. We do it already, in so many ways, in our everyday lives, so why wouldn't we do it in health care? We need to take this opportunity to introduce these advances into our health care system in a way that is safe and reliable, and that's precisely what we're doing. In fact, I think, aligned with this but slightly separate, consumer-facing digital health care is perhaps one of the greatest, if not the greatest, tool for patient empowerment.

We have to remember that even when it comes to accessing one's own medical record—and it is your medical record; we have custodians, who are doctors and hospitals, that protect and contain that information for us, but it is your record. Enabling Ontarians to access that in a safe, reliable and easy way is one of the challenges that we have, especially if you have visited three or four or five hospitals and have had half a dozen digital images taken—CT and MRI. You've got a family doctor and you've got a couple of specialists. Being able to integrate that holistically will not only result in better outcomes, better patient care when you have those interactions with the health care system, but it also empowers the individual to take control of their own health care and ask the right questions and be assured that the right solutions are being sought. That kind of transformation is absolutely imperative to the future of our health care system.

Of course, we know that patients expect and should expect to receive the best possible care when they need it, so our government is working to transform the health care system so that the patient has a better experience and a better result. We need to keep finding our way—our own way, a uniquely Ontario way—when it comes to building on universal health care to help all patients. Universal health care binds us all together. It's one of the things we're most proud of as Ontarians and as Canadians. It has made us, I believe, a more cohesive society. In doing so, it also makes us more successful as a people. Success in education, in the economy, in the environment, science, the arts and all other fields of endeavour has a common enabler, and that's people who are as healthy as possible.

Universal health care means that a young mother with a feverish baby on a Saturday night has somewhere to go or someone to call. If that fever is a symptom of something more serious, a doctor or other health provider will intervene, and intervene early and successfully. The requisite supports will be provided so that that child's life can be defined not by illness but by achievement. By middle age, if that mum worked too hard—and no doubt, having kids, she did—and if she stressed a little bit too much or doesn't feel quite right, she herself also gets the necessary care or wellness plan. That same universal health care will help her in her senior years to stay mobile and to stay healthy. While that child is pursuing her or his dreams, mom and her spouse will live life to the fullest still. When that elderly woman sees her spouse, friends or relatives pass on, she's not alone, because she contributed to a community throughout life, and that community will be providing her with compassionate care until the end of her life.

Universal care meets the universal needs that we all share. We all want to be as healthy as we possibly can be. We want those whom we love to be well cared for. That's why our government has embarked on this transformation process.

Part of my responsibility as minister is to lead the implementation of our government's plan for health care, but another important aspect of my role is to ensure that we're prepared to meet the challenges of the ever-changing health care needs of Ontarians.

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

Hon. Eric Hoskins: Thank you. Right now, our hospitals are seeing an increase in the number of patients

passing through their doors, and many of their most vulnerable aging patients are seeing an increased length of stay in hospital.

That's why Monday's announcement was so important: $100 million invested this fiscal year into our hospitals and other spaces to create 1,200 new acute-care beds in hospitals this calendar year; nearly 600 transitional spaces to pull people out of hospital, where they don't need to be—they're no longer acute, but they need that support and help to transition properly back to the community—and $40 million of new funds this fiscal year for home care.

There's no doubt we'll have plenty more to talk about over the next 13 hours of estimates, I believe, give or take. I look forward to it. I know it is often challenging, and I wish I had all of the answers at my fingertips or in memory to the very serious and appropriate questions that are asked by all three parties. But the commitment that I make—and I know my deputy shares this—is to do our best to be as forthright, open and transparent as possible to address the questions that come before us in the coming hours.

The Chair (Ms. Cheri DiNovo): Thank you, Minister.

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

Mr. Michael Harris: Good afternoon, Minister, Deputy and staff. I look forward to our next 13 hours, for as many I'm going to be here for. I've got a couple of different topics. I know we have two rotations. We'll start off with our rare disease communities.

I'm looking at a news release from your ministry on September 2, 2016. You announced back in February 2016 your intention to strike a working group. Of course, that was in response to a select committee that I had proposed and debated in the Legislature. Unfortunately, you and your government defeated that call for a select committee that would provide an opportunity for rare disease patients across the province, in an open, legislative format—we've had much success with those in the past: on sexual harassment, developmental disabilities and mental health. You didn't move in that direction, unfortunately, but you did strike a working group co-chaired by Dr. Ronald Cohn, pediatrician-in-chief at the Hospital for Sick Children, and Scott McIntaggart, senior VP, University Health Network.

You said in your own bulletin dated September 2, 2016, that that working group would submit an interim report in the fall of 2016. It's now October 2017. Where is the interim report that was due, or that you'd said you would submit, by the fall of 2016?

1620

Hon. Eric Hoskins: I appreciate the question, and I appreciate it more because I know this is an issue that's very important to you. Although we have, at various stages, differed slightly in terms of our approach, I would hope and I believe that we share the same goal with regard to improving and enhancing care and support and health care and access to medications for individuals with rare diseases.

The working group that was established—and you're correct; it was co-chaired by Dr. Ronald Cohn, who's the pediatrician-in-chief at the Hospital for Sick Children, as well as Scott McIntaggart, who is the senior vice-president at UHN. Coincidentally, they met today. We anticipate getting the final report of that working group this fall, in the coming weeks. I am enthusiastically anticipating that report, and of course I'll be happy to share it with you.

Mr. Michael Harris: Yes, good. How many times roughly would they have met over the course of the last year or so? Was there a framework for meetings that they put up? I remember Dr. Ronald Cohn talking about his participation in this working group, that he had no intentions of participating if it was going to be another exercise. I'll draw your attention—back in the day, your government did a report, I believe in 2010, on this as well. It sat on the shelf, and here we are again with the working group. How many times have they in fact met since the striking of this working group?

Dr. Bob Bell: I can't speak to the exact number of times they've met.

The Chair (Ms. Cheri DiNovo): Deputy, could you just introduce yourself?

Dr. Bob Bell: I apologize, Chair. This is Bob Bell, Deputy Minister of the Ministry of Health and Long-Term Care.

I can't give you the exact number of meetings. It's possible that may materialize while I'm talking, from the group behind me, but I can tell you that I've spoken to Dr. Cohn on five or six occasions, that his interim report has been received by the ministry verbally and his report has actually been supported by the Critical Care Services Ontario secretariat.

What we do know is that they anticipate implementation around three individual working groups. These working groups will establish a hub-and-spoke care provision network for patients living with rare diseases in the province, develop a plan to improve access to novel genomic diagnostics, including whole exome sequencing and whole genomic sequencing, which, as you know, is the methodology which has been—foundational work done by Dr. Steve Scherer at the Hospital for Sick Children, who has advised Dr. Cohn through this process.

As you also know, members from CHEO, which established the BORN registry, have been members of the steering committee expert working group, and they have defined the specifications or requirements for a rare disease registry.

We're thinking that these three working groups will serve as the appropriate focus for implementation. We're particularly excited about the opportunity to develop genomic testing here. As you know, sometimes these patients present with symptoms that indicate extremely rare diseases that may be shared by 10 people around the world. Families network around the various mutational elements that are diagnosed by whole genomic sequencing, and we hope to make that information available online so that parents can network and share their children's symptoms as time goes forward.

We're excited about the advice received. We also have an implementation framework established through the Critical Care Services Ontario secretariat that we think will not only help us get good advice from this group but obviously implement it across the province as the key step.

Mr. Michael Harris: You're saying you received a verbal interim report, but when do you expect to actually receive a document from this working group?

Hon. Eric Hoskins: I think I can speak to that, and—

Mr. Michael Harris: Or have you already received an interim report? I believe I asked you a question in the Legislature some time ago, and, if I can recall, you maybe even alluded to the fact that you had an interim report that you had read or viewed—I know you weren't too far off.

Hon. Eric Hoskins: Yes. This was a committee that was struck, I think, in fall of 2016. Indeed, we have received the report of the working group. The—

Mr. Michael Harris: How long have you had that report?

Hon. Eric Hoskins: We have had it for, certainly, several months.

Mr. Michael Harris: How come you haven't released it? What's the holdup?

Hon. Eric Hoskins: Part of it is technical; part of it is that we're reviewing the recommendations. As the deputy said, we are planning for implementation and to develop an implementation steering committee. Since we take seriously this report, we want to have an implementation strategy and be very deliberate in terms of a timetable and framework for implementation of the various recommendations. In fact, we anticipate in the coming few weeks that we should be able to—my understanding is that it's being made AODA-compliant, and we will be making it available publicly in the coming weeks. But it will provide us with the opportunity, I think, to respond directly to the recommendations that are there, the work that we've been doing over the past months—

Mr. Michael Harris: All right, so just to be clear: The deputy said he had a verbal report, but you actually have a copy of the interim report which in turn you hope to make public in the coming weeks.

Dr. Bob Bell: The other follow-up, Mr. Harris, is that the various subgroups met up to eight times over the course of the year.

Mr. Michael Harris: Okay. That's good. I'll await that, I suppose. I guess I'd ask that the report be tabled with the committee or submitted to the committee. But I'll hold you to the fact that you're going to release that in some sort of public way within the next few weeks, because we were expecting that in the fall of 2016; we're now in the fall 2017. You know what's happening next spring—and these folks continue to wait, of course.

On that note, much to do with the rare disease community is the backlog or the pipeline—we're going to get into OHIP+ perhaps later on. The regulatory process for approval of treatments in Ontario is, frankly, extremely painful. We're going to maybe get into some pCPA stuff—and I think I see Sue in the back there; you'll maybe want to come up and join us.

Minister, do you feel my frustration and perhaps others' frustration with the process over at—you've got Health Canada; you've got CADTH; it goes over to, in some cases—and I'm going to bring up this new acronym for cancer drugs—the pCPA: just a gridlock. You think the 401 is bad on a rush hour morning; pCPA is, frankly, an embarrassment—the process. Only a few years ago, I read that it was about 167 days to get an approval; we're up to 341 now. What would you say to the reason why we're now over 300-and-some days before we see approvals? Do you share my frustration with this regulatory process?

Hon. Eric Hoskins: Well, I do and I don't.

I agree, in the sense that it can be made better. The federal government has committed—and we're working together with them to this end—to better coordinate and streamline our two processes. The approval and licensure process that Health Canada is responsible for—which is, in many ways, substantially different than the process that the provinces and territories go through when they make a decision based on evidence and science and efficacy and evidence of improved outcomes when they review drugs that have been approved for licensure in Canada. That next step is up to the provinces and territories. But the more we can coordinate and indeed, probably, overlap those processes—and that's the work that we're doing—I think that would be an improvement. So I agree in that respect.

1630

Where I am perhaps more optimistic than you are, if you'll allow me, is that when we look at the present-day reality compared to prior to the pCPA, there have been enormous improvements in a variety of channels. So far, 288 brand products have been reviewed and supported by the pCPA since 2010, and 587 generic products have been submitted to the centralized price confirmation process as of this past June, whereas we had tremendous disparity.

I mentioned Health Canada and the provinces. All of the provinces and territories had their own system of approach and approvals in helping them decide whether or not to add a particular drug to their formulary. We now have a consolidated, national, integrated approach, which, I agree with you, can always be improved, and we are working—

Mr. Michael Harris: You would think, though, by consolidating the provinces to one negotiation scheme through the pCPA, that you'd decrease times. Since 2015, as I said, it was 167 days from CADTH recommendation to completed negotiation over at pCPA. Now, in 2017, it's over 300 days.

Tell me this—Sue, you'll probably know better than most—how many negotiations were completed in 2017.

Ms. Suzanne McGurn: Suzanne McGurn, assistant deputy minister and executive officer for the Ontario public drug program.

Thank you very much for the question. Just to make an introductory comment, I think it's important to recognize that just over the period of time of the last two years, the actual volume of medicines that are proceeding through has grown exponentially. Just to reiterate, 288 brand products have been reviewed by the pCPA from 2010 to June 2017, with approximately 50% of that activity in the last fiscal year, 2016-17—and that volume is continuing—for a recognition that there has been a significant change in volume. It's not slowing down the process; it is volume-related.

Specifically with regard to timelines, I would just comment that the average timeline—there is quite a range. We have had files closed in as little as 0.2 of a month—a couple of weeks—up to 29 months, with the median being nine months and the average being eight months. That's the actual negotiation.

Mr. Michael Harris: How many files did you close in 2017?

Ms. Suzanne McGurn: I don't have 2017 whole, but I can bring that number back to you—

Mr. Michael Harris: What about fiscal 2016?

Ms. Suzanne McGurn: We have had in total, in fiscal year 2016-17—sorry; I don't—

Dr. Bob Bell: Fifty.

Ms. Suzanne McGurn: Fifty files within HTA were closed by the pCPA.

Mr. Michael Harris: Fifty files closed?

Ms. Suzanne McGurn: Closed.

Mr. Michael Harris: What are the options for outcomes—negative, positive? What is the terminology you would use?

Ms. Suzanne McGurn: There's a variety of things that can happen. The pCPA makes a decision to negotiate through the pCPA with the involved jurisdictions. They take into account advice they are given, particularly from CADTH. It can be pCODR for the cancer drugs, or it can be CDR for the non-cancer drugs.

As well, Quebec is involved in pCPA now, which means that we also take into account the recommendations from INESSS, which is the equivalent—

Mr. Michael Harris: But what's the actual outcome?

Ms. Suzanne McGurn: The actual outcomes of the negotiations can be varied. I'll try and do them off the top of my head. You can negotiate and get an agreement; you can negotiate and not get an agreement; you can make a determination that it is a product that will not be negotiated.

There are circumstances where we close a negotiation but are willing to reopen, and it can be in a couple of circumstances. One would be a reopening because a product has gone back to CADTH and been reassessed, and the recommendation has been changed. Alternatively, the manufacturer has come back to us with an alternative approach.

Mr. Michael Harris: Okay. So on that note, then, negative—you've got negotiate, agreement; negotiate, non-agreement; and then closed. Those are the three aspects I'm looking for.

In the last fiscal year, how many negotiated agreements have you actually completed?

Ms. Suzanne McGurn: I don't have that detail with me.

Dr. Bob Bell: We can provide you with that information. We'll look at providing that.

Mr. Michael Harris: I was hoping you would have that.

Ms. Suzanne McGurn: I don't have it broken down by that fiscal year.

Hon. Eric Hoskins: She's good—

Mr. Michael Harris: She is good.

Hon. Eric Hoskins: —but she may not be quite that good.

Mr. Michael Harris: I have heard about this woman. I have heard lots about her. I know she's great.

Ms. Suzanne McGurn: If I go back and I look at my BlackBerry in a few moments—

Mr. Michael Harris: So I guess I can't ask you how many negotiated non-agreements you had.

Ms. Suzanne McGurn: If I can do it rolled up, I have some—

Mr. Michael Harris: I hate to do this. This is rapid-fire, because I've got 20 minutes.

The Chair (Ms. Cheri DiNovo): Mr. Harris, you've got just over two minutes.

Mr. Michael Harris: I've got two minutes left.

Ms. Suzanne McGurn: Just quickly, I'll give you some numbers that address that.

Mr. Michael Harris: How about before you go—we're going to have 13 hours together—I just want you to come back to me sometime with: negotiated with agreement for the last fiscal year, at the least; you could go for the last couple fiscals, but last fiscal would be appropriate, and then 2017 onwards; and negotiated without agreement, and how many were closed. I just want a list of that.

I'll go back to the reason I'm asking. A lot of folks in the rare disease community, with a lot of great new, innovative treatments out there on the market, see that other jurisdictions like the United States and European countries have access to a lot of these innovative treatments, and it's this process that gets bogged up with negotiation. I didn't get into this new acronym that came out—pCODR, I believe it is?

Ms. Suzanne McGurn: pCODR.

Mr. Michael Harris: Yes, another new one for drugs. But go on with what you were going to say.

Ms. Suzanne McGurn: I was just going to say that the information that I do have with me—I will get the information that has been requested. I would just note that the information that dates up to and including 2015-16 was that:

—160 joint negotiations had been completed through the pCPA process, and of those, 11 resulted in no agreement;

—42 negotiations were active, which means negotiations are currently under way and have not yet concluded;

—23, at this point in time, were being considered, which means they were taking into account the advice that has been given with the jurisdictions; and

—63 other brand products had been considered and a decision made not to pursue a negotiation.

Mr. Michael Harris: Those numbers, though—I didn't hear that any of those—

Interjection.

Ms. Suzanne McGurn: No, 160 negotiations have been completed, so if I go back to the number that I had previously—

Mr. Michael Harris: Again: negotiated with agreement.

Dr. Bob Bell: And only 11 of those, right?

Hon. Eric Hoskins: Only 11 of those resulted in no agreement. Some 160 joint negotiations have been—

Mr. Michael Harris: How many, though—

Ms. Suzanne McGurn: I will get you—

Mr. Michael Harris: That's the number I'm looking at.

Hon. Eric Hoskins: It's 149.

Mr. Michael Harris: I think my message here, Minister—I'm sure you're well aware of this—is that, again, we've gone from 167 to 303 on average, let's just say; I know your numbers perhaps show otherwise. This community sees this process as just a way to stall and delay, and we're talking about people—we're going to get into OHIP+ next, and I think it has a lot to do with each other that these people go without, frankly.

The Chair (Ms. Cheri DiNovo): Mr. Harris, your time is up.

Mr. Michael Harris: Anyway, thank you, Suzanne. I really appreciate you being here, and I'm sure we'll talk to you more.

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

M^me^ France Gélinas: Actually, please come back. I just want to finish what he was on, if you can, but it has to do with the Canadian Association of Provincial Cancer Agencies, CAPCA. Is CAPCA able to decide or influence which drugs will be reviewed, or is it still submission-based by the manufacturer?

Ms. Suzanne McGurn: This was talked about briefly yesterday. When cancer drugs are approved, historically, first in the door, they're assessed by Health Canada. They're then assessed by pCODR, which is the health technology piece for cancer drugs. A recommendation is made. They then go to the negotiations portion. Recognizing the previous question, we are looking at how we better overlay those so that they're not sequential.

That being said, what has historically happened is that we negotiate the agreements, and then it becomes each of the individual provinces to be able to make a determination of when and how they will add those products if they're cancer agencies.

1640

There are lots more things to take into account than just the cost of the drug. There is chemotherapy chairs, there is staffing—there's a lot that goes into it. In recognition that the pan-Canadian Pharmaceutical Alliance is looking at trying to improve our consistency, we're trying to have the cancer agencies assist us in making sure that we have consolidated advice. CAPCA does not make a decision about any drug—does not stop or start any drug going through the approval process. The work that is being done by CAPCA that was talked about yesterday by the CDIAC is further advice to the PCPA on considerations they may want to take into account that go beyond the health technology assessment. It may have implementation considerations: things that we need to think about that they were individually doing and were being thought of after the negotiation.

The recommendation by CDIAC does not prevent or expedite activity by the pCPA. It is simply another piece of advice. The pCPA then proceeds to negotiate, and it remains the individual jurisdiction's ability to put the products on through their processes.

I appreciate that the timeline appears long in some of these, but Ontario does have a history of being one of the fastest jurisdictions to list products once they are completed through the process.

M^me^ France Gélinas: Is there a chance that CAPCA would include people with lived experience—or solely cancer agency?

Ms. Suzanne McGurn: The group that is doing this work within CAPCA—I actually think I have verbatim language—includes experts in the field as well as—

Dr. Bob Bell: They have a citizens' panel.

Ms. Suzanne McGurn: They have a citizens' panel representative as well as a family and caregiver with lived experience.

M^me^ France Gélinas: That advise CAPCA or that are members of CAPCA?

Ms. Suzanne McGurn: Just for clarity, CAPCA is the Canadian Association of Provincial Cancer Agencies. When folks are talking about the area that's giving us advice, it's referred to as the CDIAC. The CDIAC does include, as Dr. Bell said, a citizen, a family member and a caregiver. They're selected from individuals with lived experience from the patient and family advisory committees from the cancer agencies.

Dr. Bob Bell: Maybe I could just add one comment. This is Bob Bell, deputy minister.

The complexity of cancer drugs—it's no longer single drugs being provided to patients; it's a series of biologic agents, quite often. What we do is we negotiate the price. Remember, these are negotiations. That's why they sometimes take a long time: because the company refuses to give us cost-effective pricing. What CAPCA is doing is giving us advice, giving pCPA advice, not just about individual negotiations but about the formulary that should be used with the addition of each new drug. It isn't just adding one drug; it's changing the second-line, third-line and fourth-line therapy in an entire formulary.

That has been enormously useful in ensuring the cancer patients get access to the best drugs as quickly as possible, spending taxpayers' money in the most effective way possible.

M^me^ France Gélinas: Okay. I just wanted to finish. You're free to go. I reserve the right to call you back.

Dr. Bob Bell: She's just paroled.

M^me^ France Gélinas: Exactly.

Yesterday, Deputy, when we were talking about hospital overcrowding and overcapacity, you said that you had asked the hospitals how many beds each hospital could accommodate if operating funds were provided. On the record, you said that you heard from hospitals that it was between 2,000 and 3,000 beds. Do you—

Dr. Bob Bell: No. If I did say that, I didn't mean to. I think the right number—

Hon. Eric Hoskins: It's approximately 2,000.

Dr. Bob Bell: —is about 2,000.

M^me^ France Gélinas: About 2,000?

Dr. Bob Bell: About 2,000.

M^me^ France Gélinas: Okay. Can I have a copy of those findings that you gathered together to make up the 2,000?

Dr. Bob Bell: We'll certainly look into that.

M^me^ France Gélinas: All right. You also shared with us yesterday that at midnight, the different hospitals will feed in to you their occupancy. Is this something that you can share with the committee as to: What do those numbers look like, what do the aggregates look like—and just for getting us started, if you could give me a month of what this looks like, last month or the last—

Hon. Eric Hoskins: Yes, I'm happy to speak to the ministry about that.

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

Then I will go back to hospitals for a little while. I have here—I will share it with all of the committee—the senior leadership report of Thunder Bay Regional Health Sciences Centre. They reported to their board of directors on October 4, so that's their last board of directors meeting.

I will just read into the record what it says. Thunder Bay Regional Health Sciences Centre "continues to operate in surge capacity. As part of our commitment to meet the health care needs of our patients, the following internal strategies are in effect to increase hospital capacity:

"Six large private rooms have been converted to semi-private accommodation

"Eight surgical day care beds have been converted into an in-patient ... unit. As a result, a patient prep and recovery area has been created in the diagnostic imaging department to handle outpatient" diagnostic imaging "activity and relieve" the surgical day care "overcapacity.

"Treatment rooms and family rooms are being" fully "utilized ...

"And, patients have been cohorted as much as possible."

He goes on to make his report on emergency—ED patient flow, they call it:

"Throughout the summer months, overcapacity has remained an ongoing challenge." Emergency department length of stay "for admitted patients has increased from 37 hours in June to 42.5 hours in August (target 27 or less). On average, each morning, there were 24 patients waiting in" the emergency department "for an in-patient bed."

The CEO, Jean Bartkowiak, goes on to say, "Our hospital has 375 acute care beds.... On September 27, there were 398 admitted patients." I'm strong in math; that's 23 more than they have beds for.

On Monday, you announced 12 additional beds at Thunder Bay Regional Health Sciences Centre and 10 short-term transitional care spaces in a partnership between Thunder Bay Regional Health Sciences Centre and St. Joseph's hospital. My first question is, are you confident that this will meet the needs of the people of Thunder Bay?

Hon. Eric Hoskins: When I look at any particular hospital situation, I look at the continuum of care, everything from the volume of patients that they see in their ER and the complexity of those patients to their in-patient situation, their ALC rate and what's available outside of hospital as well in terms of decanting ALC patients particularly.

We made an important investment about a year and a half ago, I believe, where we significantly increased the availability of long-term-care beds within Thunder Bay. Part of the rationale—in fact, it was in direct response to the bed capacity challenges that Thunder Bay was facing. It did provide significant relief, enabling a significant number of ALC patients to move out.

We have allocated in this week, as was mentioned by yourself, an additional 12 acute in-patient beds to Thunder Bay regional. We also have set aside for the North West LHIN an additional 19, in addition to the allocation that is being provided to Lake of the Woods hospital, but there are 19 beds. What we did quite deliberately is, based on the work that we did with the Ontario Hospital Association to establish what beds, theoretically, in conventional spaces were available across the province, we targeted those that we felt were most in need of those resources.

In the case of Thunder Bay regional, as I mentioned, it's the 12 that we allocated, valued at just under $1 million this fiscal year. But we also set aside for each LHIN, in co-operation with the ministry, in short order, some considerations that hadn't yet necessarily been finalized at the time of Monday's announcement. Also, as we get closer into the flu season, it allows us the flexibility to add beds so that there's an additional allocation apart from the targeted investment that was announced for Thunder Bay regional, which is available to us and to the LHIN, should we need it.

1650

M^me^ France Gélinas: Thunder Bay is on target for a $2.8-million deficit. That was as of August 31.

The reaction in Thunder Bay to your announcement was, and I'll read the headline, "New Beds Aren't Enough." It goes on to say, "It has taken at least a decade but the provincial government has finally acknowledged extremely crowded conditions in Ontario hospitals by funding new beds." It goes on to say, "The government has stubbornly refused to act sufficiently and decisively

despite reams of reports clearly identifying the problems over many years."

The people in Thunder Bay don't feel that the additional beds that you and I are just talking about are going to solve their ongoing problems, but you do? Do you think it will—

Hon. Eric Hoskins: I'm sorry, I missed who you were quoting.

M^me^ France Gélinas: I was quoting the headline in Thunder Bay's paper.

Hon. Eric Hoskins: It was a long headline.

M^me^ France Gélinas: The headline is, "New Beds Aren't Enough," and then I read you the beginning of the article.

Hon. Eric Hoskins: So that was the journalist, him or herself, you were quoting, who was making that determination?

M^me^ France Gélinas: Correct.

Hon. Eric Hoskins: Certainly we've worked closely with Thunder Bay Regional Hospital on the one hand. With respect to understanding the object of this investment, it was immediate investment in many, if not the majority, of cases over the next two to four weeks. These were conventional beds that were ready to be opened and could be opened in a matter of days.

With each hospital—that's the intersection, right?—in terms of looking at capacity, looking at what was available and immediate, which does not preclude further measures down the road, either through that set-aside, as I mentioned, of the 19 additional beds that are available to the LHIN, but of course, as we go forward looking at longer-term solutions to the capacity.

I would imagine that the people of Thunder Bay—and I certainly know this from my conversations—appreciated the measures that we have taken over the last couple of years, which include—and I don't have before me the exact number of long-term-care beds that were made available to aid with the decanting but also the roughly $6.6 million provided this fiscal year to the operating budget of Thunder Bay regional for them to be able to provide that care with the unique properties that they have.

M^me^ France Gélinas: Have you, or your staff or members of your ministry, gone to see what those six private rooms made into semi-private rooms look like? Did you go and have a look to see what surgical day care now looks like in Thunder Bay? Did you go have a look to see what it looks like in the treatment room and the family room at Thunder Bay Regional Hospital?

Hon. Eric Hoskins: I've been to Thunder Bay Regional Hospital many times, a couple of times this year alone, first, announcing the opening of their vascular surgery program and then announcing the funding for their cardiac surgery program for northwestern Ontario based at Thunder Bay regional, which is obviously important and well received by the population. I've been there quite a number of times.

Again, I look at this as a continuum, that our additional $40-million investment this year on top of—remember, over the last several years we've increased our home and community care investments by about $250 million a year, or 5%—investing in that in terms of avoiding them to be in the hospital in the first place or getting them back home quicker.

Perhaps somebody behind me has the number of additional long-term-care beds that were opened just recently in Thunder Bay as well at Bethammi: 111 beds that were opened recently at the Bethammi long-term-care home. Again, focusing on that side of the equation as well. That was done in concert with the hospital itself when we were asking them what solutions they felt would best address the challenges they're facing. The infusion of $6.6 million in new funding this year on top of their existing budget, as well as the 12 beds immediately, which—and we'll have to talk to Thunder Bay regional but, again, one of the conditions of funding was that they would be ready to open in a matter of days or short weeks, and the set-aside of the additional 19.

Collectively, when you look at that, and the tremendous efforts they're doing at the hospital itself, I think it's a very comprehensive way, which doesn't preclude more decisions and more actions and more investments in the future.

M^me^ France Gélinas: I will move on to Kingston. In August, we released a freedom-of-access for Kingston General Hospital, which has operated as many as 31 unfunded beds in unconventional places. That's beyond regular beds. The hospital recorded an acute care and medicine occupancy rate of up to 103%. People—mainly physicians and front-line workers in Kingston—say that this level of overcrowding should not be normal in Ontario.

Again, although they are operating 31 unfunded beds in unconventional places, on Monday, you announced 25 beds and two bassinets for the Kingston Health Sciences Centre. Do you figure that this will solve the overcrowding issue in Kingston?

Hon. Eric Hoskins: I think it's an important and substantial investment in the Kingston Health Sciences Centre. The dollar amount, approximately, in this fiscal year—new money that was not in the spring budget—is an additional $2.5 million. And you're correct: that is 25 additional acute care beds available in that hospital and two new neonatal intensive care beds.

It's a substantial investment. I don't know what the set-aside is for the South East LHIN. Perhaps—

Mr. Lou Rinaldi: Fifty-one.

Hon. Eric Hoskins: Fifty-one.

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

Hon. Eric Hoskins: There's an additional set-aside of 51 beds for that LHIN as we move forward to further allocate. And that is the intention: to allocate.

M^me^ France Gélinas: How many of those 25 beds are guaranteed to still be funded come April 1?

Hon. Eric Hoskins: I'm sure you're familiar with the normal budgetary process. These funds were not articulated clearly in the budget in the spring that was passed in

the Legislature. This is an in-year investment, typically, uniformly across ministries. We secured the funding for the balance of this fiscal year, again, because it was not articulated—

M^me^ France Gélinas: Through your budget or through Treasury Board?

Hon. Eric Hoskins: Through Treasury Board, because the budget had already been passed and implemented as of late spring. As is typical and natural and normal, we've already begun the conversations towards the next budget early next year. Naturally, a discussion with regard to our hospitals, including their allocation of funding, including the measures that we put in place this week to address a growing and aging population and certain pressures that certain hospitals face, is part of that conversation.

M^me^ France Gélinas: Thank you.

The Chair (Ms. Cheri DiNovo): We now move to the government side. Ms. Hoggarth.

Ms. Ann Hoggarth: When I'm out in my riding, I always speak to my constituents about what matters most to them. I could say that, every time I ask them, health is either first or second. In particular, I have countless constituents who talk to me about how important it is to ensure that all Ontarians have access to the medications that they need to live a healthy life.

I see it in kindergarten. There quite often are little ones who are off for a couple of days. They come back, they've been to the doctor, but for some reason, it doesn't seem they're getting any better. When you speak to the parents, quite often it's because they didn't get the prescription. Usually, they don't say that they couldn't afford it; they say that they haven't had time or something like that.

This government agrees that having access to the necessary prescription medications is critically important in this province. That's why I'm proud that our government has taken the major leap toward establishing a provincial pharmacare program in our province.

Minister, we know that providing medications to improve the lives of children and families is an important priority for you and your ministry. Can you please provide an overview of some of the public drug programs available to Ontarians, and can you provide details on some of the new initiatives being rolled out?

Hon. Eric Hoskins: Thank you for that important question. I'll kick it off, but Suzanne, who is the—if I can call you the godmother of OHIP+. Suzanne, you want to listen to this, because—

Ms. Suzanne McGurn: It's your office.

Hon. Eric Hoskins: I know it's my office, but they should listen to this as well—but in a good way.

I think many of you know that I have been relentless, joined by the Premier. She has shown incredible leadership and courage on the issue of pharmacare nationally and given me, as the Minister of Health, tremendous support.

1700

Last year, when we had the opportunity to host the federal-provincial-territorial meeting of health ministers after two previous meetings, one in Banff and one in Vancouver—where I cajoled, convinced and in some cases probably bothered my colleagues on my quest and many Canadians' appropriate quest for universal pharmacare in this country, which so many people believe is not only necessary, but wholly attainable—we were looking for an opportunity to demonstrate that it was possible. So that was the task that I gave to Suzanne and her team, and she came back with focusing on children.

I can't remember what we called it—

Ms. Suzanne McGurn: "Kids First."

Hon. Eric Hoskins: "Kids First," yes. She conceived of what will shortly become a reality. But I want, in no uncertain terms—and I know it's not only Suzanne, it's many people; but if there is one person who I think has tremendously helped us tip the balance of providing this important aspect of our health care system not only in this province, but also nationally has given us an anchor which is being looked at and viewed so positively by so many—and not just advocates for universal pharmacare, but also other provinces and territories that think if Ontario can find a way to make it work or at least head down that path, they might too.

I promise I'm going to leave you a couple of minutes at least. How many minutes do I have, Chair?

The Chair (Ms. Cheri DiNovo): You have about 15.

Hon. Eric Hoskins: Okay. I'll try to be brief.

So we presented "Kids First," a child pharmacare program, to the FPT meeting last October, I think it was, here in Toronto that I chaired. We were asked very directly—tasked, I suppose, by the FPT, by the other provincial-territorial health ministers—to return to the FPT meeting that happened just last week with a more fulsome understanding and description of a framework for what a pharmacare program focused on kids might look like. Well, we kind of did one better than that.

Again, to the credit of the ministry, Suzanne and her team, and especially the Premier, as we all know, in the spring budget, the gift of absolutely free medicines for four million Ontarian was proposed. Fortunately, it was passed, and that's the reality. That's the other side of the equation that Suzanne is now burdened with. I have 120% confidence in her that it will be accomplished, and accomplished beautifully and seamlessly. But she's now tasked with delivering on this promise, which I'm absolutely—

Mr. Michael Harris: No, you are.

Hon. Eric Hoskins: Yes, and me. Okay, so ultimately me. It's my burden; it's her task.

Come January 1, four million Ontarian children and youth up to their 25th birthday will have access, absolutely free of charge, to 4,440 medications, the entire Ontario drug benefit formulary.

The scenario becomes the mum with the kid with asthma with a prescription for, let's say, a Ventolin puffer-inhaler, is going to be able to walk into any one of the pharmacies anywhere in this province with that prescription and—the first time, at least—her child's OHIP number, but then it will be on record as well, so that's

probably the only time that will actually have to be produced. In return for handing in that prescription to the pharmacist, she is going to receive the medication that may, in fact, in that case, be lifesaving for that child, that Ventolin inhaler or puffer or whatever it is for that individual's particular condition—no annual deductible, no copayment, no up front fees, nothing of that sort at all. That will be available to four million.

The 22-year-old at college pursuing a degree, who is unfortunate enough to be—and it's regrettably common—suffering from mental illness. Perhaps that individual is on a medication to assist them, to give them the ability and the support to overcome or at least manage that condition. That individual will be able to walk in with a prescription and their OHIP number and get absolutely free of charge what they might have spent excessive amounts of money for.

The overall context is that we know at least one in 10 families—probably significantly more—across this country do not fill their prescriptions because they can't afford them. I know that from personal experience, as well, practising as a doctor with primarily a population of patients and clients who were from a lower socio-economic group. I knew that often, absent insurance, I was facing a family or an individual who I knew wouldn't purchase the medication because they simply couldn't afford it.

This is a big step forward. I think this is the biggest change to medicare in this province since medicare itself 51 years ago. On that note, it's also important to recognize that medicare, when it was conceived of and created and deliberated nationally, following Saskatchewan's example from Tommy Douglas, was always conceived of as having both parts phased-in—but the universal health care was always envisioned to have medicines as part of that.

Then the last thing I'll say, perhaps, is—how many minutes left, Chair?

The Chair (Ms. Cheri DiNovo): Eleven.

Hon. Eric Hoskins: Eleven; good, we have lots of time—it really is my responsibility and my burden, but I kind of created it for myself.

Let's go back less than a week in time. We were asked to come back to that at last week's federal-provincial-territorial health ministers' meeting, with a new federal health minister, and present and report back on an idea of what a child pharmacare program might look like in a Canadian context.

Well, instead, formally on the agenda both days there was a discussion of national pharmacare. In addition to that, I co-hosted—and it was co-organized by the health minister, Sarah Hoffman, from Alberta and myself—a breakfast briefing and discussion and meeting with civil society advocates like the Canadian Medical Association, the Canadian Federation of Nurses Unions, Canadian Doctors for Medicare, the Canadian Labour Congress and Steve Morgan, who is a health economist from the University of British Columbia. We had a host of individuals there and we had most health ministers there where we were able to have a conversation in that environment about how it could be attained.

The amazing thing, and perhaps the last thing I'll say is, coming out of those two days where we had it on the formal agenda both times, and then the breakfast meeting, as well, those discussions resulted in—and I'd encourage you to look at it; it was really quite remarkable—the communiqué that was issued by consensus, by all provincial, territorial and federal health ministers, that tasked, once again, our respective officials across the country at all levels of government—or at least provincial, territorial and federal—to develop the "how" nationally: to come back with options on what national pharmacare could look like, and hopefully, and, I believe, will look like. I believe it's inevitable. I really believe the stars are aligning for it, and I believe that it's not only inevitable, it's attainable and it's cost-effective, and there's a tremendous cost benefit to it.

The communiqué tasks officials at our respective levels of government to do the hard work of not asking the question of if, but asking the question of how, and coming back with the options in terms of what that framework, what the structure, what the model, or models, of national pharmacare might look like, including the important aspects of costing, implementation and timetables—all of that.

1710

We had to sort of backstop that. There was very clear direction provided by all Premiers across this country, provincial and territorial, back in July at the Council of the Federation meeting, where they directed—and this was led by our Premier, Kathleen Wynne, to demonstrate once again her courage and leadership on this file at the national level, let alone at the provincial—where the Premiers directed all of the provincial and territorial health ministers to deepen that discussion with the federal government, and to work towards that same question of how, of what it might look like. So that's the work that we're now beginning to undertake, which is tremendously exciting, as you can imagine.

We've gone from me being a pain in the butt three and a half years ago—or whenever that first federal-provincial-territorial health ministers' meeting was—when I surprised everybody over lunch and said that I believe the time had come to do national pharmacare. We've come from that, where there was conceptual, philosophical and emotional support but so many questions, to the point where we're now actually working on the architecture of what it might look like. That's a pretty tremendous place to be.

In conclusion, the steps that we're taking here in Ontario, again, to get back to the beginning, and the leadership that our Premier and our government are demonstrating with child and youth pharmacare, which begins January 1 and which includes everything from that asthma inhaler that I was talking about to many drugs for rare diseases, to cancer medications—that whole list of 4,400 medications—that really provides an anchor, and an encouragement and enthusiasm, for the rest of the country, let alone our own.

We're determined, and the Premier has said this on a number of occasions, that we see this as a major leap forward towards what we hope for and anticipate: full universal pharmacare for Ontarians. We need to figure out the pathway to get there, and we need our federal government as a partner. I believe that they are, more and more and more. That communiqué from last week is evidence of that. Certainly, across the country, we now have strong partners that are working with us to create what that might look like, and to create the "how."

Maybe some would think I'm overly optimistic. There's a wealth of evidence as well, even on the cost side, which demonstrates the savings that can accrue from a universal pharmacare program. But even that aside, the absolute same arguments were made with the introduction of universal medicare—it was a Liberal government; it was Lester Pearson. The finance minister of the day said, "We can't afford this. We've got to delay it. We can't do this now." Al MacEachen, who just recently passed away, in fact, was the health minister at the time and threatened to resign. He said, "If we don't do this now, or reasonably close to now, you need another health minister." Then, remarkably—and this is reported and documented but hardly known—Lester Pearson had a caucus meeting with his fellow Liberal colleagues and MPs and said, "If we don't do this now, or very close to now—if we need to delay it by a year, fine, but no longer—then you'll need to find yourself a new leader of your party." That was how committed they were, in the face of their own finance minister saying that it wasn't affordable. Imagine if we had decided not to do it because we felt it was unaffordable.

It's no different today. It's the right thing to do. It's inconceivable for me as a health care provider to think that access to health care and health care equity is limited to being able to go into an emergency room or it's limited to seeing your primary care provider—your doctor or nurse practitioner. It has to include access to medications. It has to. When you've got one out of 10 families across the country that don't fill their prescription because they can't afford it, there is something wrong with the system. But we can fix it.

Suzanne.

Ms. Suzanne McGurn: Good afternoon again. Thank you, Madam Chair and the committee, for providing me with the opportunity to speak here today.

I would first like to start by thanking the minister for recognizing the tremendous work and effort that the team in the Ontario Public Drug Program does. It's certainly an opportunity for us to talk a little bit about what it is we do in the program and, more specifically, where we are on moving forwards the implementation of OHIP+.

As some context—I know we've sort of jumped into some questions already during the estimates discussion—the Ontario Public Drug Program with focus on balancing access to medications with value for the taxpayers' dollars that are spent. This does involve making very difficult decisions with the broad public good in mind. It is a complex process, as we've talked about, involving many stakeholders. Since I've worked in government, I have found this portfolio one of the most interesting—the opportunity to work with patients, clinicians, advocacy groups, private insurers, employers, pharmacies, the pharmaceutical industry, federal and provincial counterparts and, in some instances, international counterparts.

The Chair (Ms. Cheri DiNovo): You have two minutes and a bit.

Ms. Suzanne McGurn: It's also a financially impactful portfolio.

The upside of that comment is that the minister covered off much of the middle part of the conversation. Perhaps what I would like to reflect on is OHIP+.

OHIP+, as the minister has spoken to, will provide coverage to individuals aged 24 and under. That will almost double our actual number of recipients covered by our Ontario Public Drug Programs, from four million to eight million, with the addition of the four million children.

As Minister Hoskins has mentioned, some of the scenarios that probably best depict how much benefit this can be to individuals: Imagine the child with type 1 diabetes who may, over the course of their childhood and young adulthood, have 120 prescriptions filled related to their diabetes. That would be a cost of $8,600. Minister Hoskins used the example of inhalers. Again, 50 prescriptions for inhalers over the course of your childhood and young adulthood would cost approximately $1,400.

We often are asked about what medicines are covered. OHIP+ uses the existing formulary. As we have been out speaking with clinicians, we're recognizing that there are opportunities for us to look at medicines that may need to be added. For example, we may cover a pill that is appropriate for an adult, but we may need a liquid suspension form for children. So we're getting that advice from clinicians in the field and we're bringing that forward so that we can look to and add those types of medicines to our coverage.

The other thing we're doing is a significant amount of stakeholder outreach, including webinars and availability to talk to patient groups; we'll be talking to universities and colleges about how to use the program, reaching out—

The Chair (Ms. Cheri DiNovo): I'm afraid your time is up. Thank you.

Ms. Hoggarth.

Ms. Ann Hoggarth: Chair, may we have a five-minute recess?

The Chair (Ms. Cheri DiNovo): Is a five-minute recess okay with everybody?

Mr. Michael Harris: That's fine. Five minutes.

The Chair (Ms. Cheri DiNovo): Okay. We'll come back at 5:23. See you soon.

The committee recessed from 1718 to 1723.

The Chair (Ms. Cheri DiNovo): Welcome back, everyone. We now go to the official opposition. Mr. Harris.

Mr. Michael Harris: Yes. Thanks, guys. I'm going to move on to another issue, which I know you'll be pre-

pared for, coming from me, and that's regional cardiac care in Kitchener, at St. Mary's. I'm hoping you're going to—

Mr. Bill Walker: It serves the Bruce–Grey–Owen Sound area.

Mr. Michael Harris: Did you want to get something in?

Mr. Bill Walker: I just wanted to say it serves the Bruce–Grey–Owen Sound area. It's very important.

Mr. Michael Harris: Yes. Of course.

Minister and Deputy, you know we had an exchange last year in estimates on this very topic. And then it was great to see the minister in KW back in, I guess, the late spring or summer time to make a re-announcement of an earlier commitment in 2012 to fund an electrophysiology suite at St. Mary's hospital—from 2012. We're, frankly, still no further ahead than where we were in 2016.

As you'll know, the Waterloo Wellington LHIN, or at least even St. Mary's—because it actually services, even outside of our LHIN into my colleague's LHIN, over 1.3 million folks. I compare that to Southlake and Trillium—similar size LHINs, I suppose: 1.8 million at Southlake, 1.2 million at Trillium.

Minister, you were back last spring and made that commitment that we're good to go, after some time, with the electrophysiology suite and had said that it would likely be up and running by fall of 2017. Like my previous question, we're now in fall of 2017 and we are absolutely nowhere with regard to this, Minister. Why do we not have an electrophysiology suite at the St. Mary's hospital?

Hon. Eric Hoskins: I remember that announcement. It was tremendous. I remember you were there.

Mr. Michael Harris: I was.

Hon. Eric Hoskins: The hospital was very excited, and the community with them, as they should be because it was the right investment, building on the nascent program that we had cultivated and enhanced and grown together with the hospital over a number of years.

My specific role, when I was there—it was a year ago this past spring, I think, right?

Dr. Bob Bell: June 2016.

Hon. Eric Hoskins: June 2016, and I announced at that time $7 million for their cath lab. Of course, I wouldn't have made the announcement if the program hadn't been approved. However, since that time—and I would say it is welcome—the hospital asked to expand that program further, so it was an enhancement to an approved program, the $7 million for the cath lab that I mentioned. That expansion would entail an additional investment of approximately $2 million capital and as yet to be determined operational.

That enhancement—if I can call it phase 2, because we had migrated as well over a number of years to where they had arrived with the cath lab funding—led to a discussion between the hospital and the LHIN and the ministry with regard to their new request for expansion and the estimated $2 million capital required for that.

I'm sure you appreciate as well that as projects and proposals are brought forward to the LHINs and to the ministry, we need to take a rigorous evaluation of the appropriateness, the cost-effectiveness and the benefit of the program. In addition, especially when it comes to cardiac centres—I think there are 19 or 20 of them around the province—we need to look at it in a broader context as well and how it fits in with the overall provision of cardiac care and the services that those cardiac centres provide.

That being said, Peter might want to come up and join us if you have additional questions. He's best placed to answer them. But that is just to provide some clarity in terms of the enthusiasm of all parties as expressed back in 2016 for our approval of what had been requested for their cath lab, and then an additional new phase for expansion coming to us, which of course, as I think you can appreciate, requires rigorous evaluation before approval.

Mr. Michael Harris: I think perhaps we'll differ slightly on this. Maybe—is it Peter?

Mr. Peter Kaftarian: Yes.

Mr. Michael Harris: —Peter, you can clarify.

You came out and announced a funding commitment for capital as well as operational funds for the electrophysiology suite—an EP lab; I'll just say an EP lab. Dr. Bell, of course, he's a surgeon, he'll know the terms properly, but I'll call it an EP lab. The approval for that capital project was given a green light. Is there a letter that has to come out following that announcement? You didn't bring a cheque, I'm assuming, then, but is there a letter?

Hon. Eric Hoskins: You don't remember the giant cheque?

Mr. Michael Harris: Who doesn't like a giant cheque? I didn't see you bring the cheque out, but is there a letter?

Hon. Eric Hoskins: There would have been a letter that would precede the announcement.

Mr. Michael Harris: Has the hospital received a letter for that commitment specific to the announcement you made in June?

Mr. Peter Kaftarian: Hi. Peter Kaftarian, I'm the assistant deputy minister of the health capital division at the Ministry of Health.

My understanding is that, yes, there would have been a letter at that time approving the project. That would be our standard procedure.

Mr. Michael Harris: There would have been a letter issued for that EP lab specific to that proposal that was submitted, and then the minister confirmed it. So how come, after a year—when they said the anticipated construction completion date would be fall of 2017—we haven't issued a tender for that?

Dr. Bell talked about the air handling and all the specifics, and I get that there's a lot of work to be done to create that spec, but how come it hasn't gone out to the street yet for that?

1730

I guess I'll go back—because we disagree, Minister, or I'm going to disagree with you. Supposedly, there was

another request, which is true, for a cardiac diagnostic testing space that was submitted back in March. I had a chance to speak to the board chair recently at the hospital. This was a specific separate application that should have had nothing to do with the EP lab.

Peter, you received another proposal from St. Mary's for this cardiac diagnostic testing space, I believe, in March, separate from the EP, right?

Mr. Peter Kaftarian: There's been an evolution in the capital process. There have been changes in the proposed scope, and I can explain a little bit about what's happening.

Mr. Michael Harris: But did the hospital not submit separately from the EP—

Mr. Peter Kaftarian: I'm not sure specifically what was the separate piece, but I can tell you exactly what's going on and how we got to where we are, if you'd like me to.

Mr. Michael Harris: Okay. Go ahead.

Mr. Peter Kaftarian: The project was approved as a vision of what they were trying to achieve, and as we worked through the capital process, which is our industry standard five-stage process, we have to do a back-and-forth with the hospital and the LHIN. In February, in their stage 2 submission—stage 2 is the functional program, and the tender place you're looking for is in stage 4. So in stage 2, they wanted to change around what was being done on the project.

We're working closely with the hospital on the changes they wanted to make. There was an original project approved. They want to look at a bigger footprint, doing different levels of procedures and volumes, and that is the dialogue that we have with the hospitals and LHINs on changes. If there's going to be a change, we need to have support from the LHIN. We need to look at the ability to fund. It's possible to change around, because things change. This project could have been planned five, six, seven years ago, and by the time it actually became a reality, the vision or the purpose of what they wanted to build was different. This would be normal, but this is part of the diligence of our process where we have the dialogue.

As of just a few weeks ago, I was personally having discussions with the LHIN CEO, with the hospital CEO, with other members of the ministry on the new ideas that they want to put forward. We asked for clarity on what exactly was originally approved, what exactly is new, and they gave us a nice, simple table that came from the CEO. We reviewed it and we asked some questions about whether they had various approvals. We provided that information to the hospital within the last seven to 10 days and now they're working on answers to those questions.

Mr. Michael Harris: Did the hospital ever ask for them to be considered very separate? At any time, did you have a conversation with hospital officials that this cardiac diagnostic testing space be treated very separately, and if it hinged at all on a potential delay for the EP lab, to hold off on that?

Mr. Peter Kaftarian: Yes. We have had that conversation—I remember it—with the CEO about whether there are pieces of this they could do separately or at a later date, and then we could just continue forward with the existing approval.

Mr. Michael Harris: Okay.

Mr. Peter Kaftarian: That's what we're working through right now, to see if that could be possible. But it may make sense to bundle them as opposed to doing two separate things, and as we work through this process, we can work through that.

Mr. Michael Harris: Has the $2 million for this cardiac diagnostic testing space been approved?

Mr. Peter Kaftarian: It has not, no.

Mr. Michael Harris: It has not. So any anticipated timelines for that at all?

Mr. Peter Kaftarian: I think it depends on how we work through, right now, the Q&A. We're cognizant of how long this has taken; I say that this is a high priority to get clarity on. The CEOs are very interested, both the LHIN CEO and the hospital CEO, with having a revised direction. The CEOs made it clear around, "We want to move this forward." So it either moves forward with the original scope and you separate out the new, or if we can figure out a way to do it together with the cost share that we have to do—we are trying to move this forward.

Mr. Michael Harris: So if they said, "Let's separate the two and let's focus on the EP lab," would that be something the ministry would entertain and move forward with?

Mr. Peter Kaftarian: Yes. It's something we—

Mr. Michael Harris: If they had said that, though, in the initial conversation, why wouldn't we have proceeded with the construction of that EP lab? Again, your minister came out—or our minister—and announced this and said, "We're going to have this up and running by the fall of 2017." We're now into the fall of 2017 and you haven't lifted a hammer up there.

Hon. Eric Hoskins: We can certainly look at that, but I think it's important—was it in February when we invited the hospital to submit both stage 1 and stage 2 in an integrated fashion? It was the hospital, at that point, when they submitted, that changed the scope and nature—

Mr. Michael Harris: Yes, it was actually separate. It's very separate. I think, perhaps, Minister, your officials should properly brief you on this one, because to my understanding they're very separate.

Hon. Eric Hoskins: Right. The note I have certainly indicated that the hospital expanded the scope, both in terms of space requirements and cost to accommodate anticipated growth in diagnostics and potential addition of a TAVI program.

Mr. Michael Harris: Right, but not for the EP lab that you announced.

Hon. Eric Hoskins: If we need to look into this, to get clarity for you on this, I'm happy to look into it.

Mr. Michael Harris: The foundation has done tremendous work. We're one of 11 full-service, or should-

be full-service, regional cardiac care centres—the only one, in fact, that doesn't have a full-service cardiac care complement of services. As I said to you before, Southlake and Trillium came on at the same time that St. Mary's did. They have EP, they have TAVI—both of them.

Ms. Ann Hoggarth: Not true.

Mr. Michael Harris: Well, no, it is true. Our St. Mary's Regional Cardiac Care Centre doesn't have both. Minister, how come in a population that St. Mary's serves of 1.3 million—

Hon. Eric Hoskins: That's why we made the investment of $7 million in 2016; the point being, I think all of us want this to proceed as quickly as possible. Sometimes, if we're looking at a cardiac program through an individual hospital, I think all of us would expect that we have a good understanding of whether all of those parts—whether it's best to deal with them as one whole at one time if it involves renovations or adjacent space, for example.

I don't know the nature of what is required on the capital side, but I think it's important to reference. We'll look into this, but what has been submitted to the ministry has significant differences from what was approved in 2016 including, for example, the potential addition of a TAVI program, which we can get into more details about. But the space requirements and the cost requirements—in fact, my understanding is that it roughly tripled the anticipated start-up volumes that would be seen. So it would be incumbent upon us as a government to do a proper evaluations with our partners, with the hospital and with the LHIN, to understand what the operational implications of that are.

It may be that separating the various elements is an appropriate way to move forward, but I think it's important to reinforce—at least this is our understanding—that there was a significant investment that was committed last year; you were there.

Mr. Michael Harris: Yes.

Hon. Eric Hoskins: And we fully intend on proceeding with this. As we were moving through the various stages which would ultimately result in the construction and operation of that facility, the nature of the projects changed.

Mr. Michael Harris: From my understanding, it hasn't. It's two separate projects.

Hon. Eric Hoskins: I think it's in the same space.

Mr. Michael Harris: I know your member from Kitchener Centre is probably frustrated as much as I am on this. We were hoping that this would have been—we've lost two electrophysiologists already. We have a brilliant electrophysiologist now practising out of London to keep his skills up-to-date. Again, a population of 1.3 million plus, a regional cardiac care centre, a wonderful facility—

Hon. Eric Hoskins: Of course. That's why we've made the investment.

Mr. Michael Harris: It's comparable to Southlake and Trillium, and we don't have EP and we don't have TAVI. You committed to it back in 2012 and back in 2016, and, again, nothing.

Hon. Eric Hoskins: But if the project that was submitted for a combined stage 1 and 2—which is bad in itself—to expedite it further—if that had been consistent with the approval that was provided in June 2016, I think we would be much further along. But it's like it's—

Mr. Michael Harris: Yes, but we'll go back and it will be like Groundhog Day—

Hon. Eric Hoskins: A broken record—

Mr. Michael Harris: —if we keep doing this.

Hon. Eric Hoskins: Yes. We're absolutely committed to the project that was approved in 2016. We're looking very seriously at the enhancements that have been suggested, and we'll just leave it in terms of whether they were integrated or whether it was a separate submission. We are as intent on getting this done as you are, so we'll continue to visit this to see what opportunities might exist.

Mr. Michael Harris: It's one thing to talk about a need that hasn't been committed to, or there's not funding attached to it, and it's another to actually have a commitment from 2012, a recommitment and an announcement in 2016—to be told that it would be up and running by 2017, this critical space, and it's 2017 and we're still no further ahead. That's the frustrating part about all of this.

Hon. Eric Hoskins: No, of course. But it's like if I get approval from my spouse to renovate our kitchen and we're replacing the kitchen cupboards and then we decide, jointly, later, that we're going to replace the appliances in that same kitchen, we need to have an understanding and I'm not making a comparison at all in terms of the importance, but we're talking about the same space and the same program, and a program and a space where what was approved in June of 2016 has been altered by the proponent.

1740

We appreciate and respect and, in fact, welcome that conversation, but it would be imprudent if we didn't do a proper evaluation of both the capital side and the operation side and, in addition, whether we would be able to. It sounds, from hearing from Peter, that we're willing to go back and see if we might be able to separate the two or not.

Mr. Michael Harris: All right.

Hon. Eric Hoskins: Notwithstanding, I want to see this done as much as you do as quickly and promptly as we can, but responsibly. It's for that responsible aspect of it that I rely on my ministry.

Mr. Michael Harris: I really wanted to get into OHIP+ today, and we'll have to save that until Tuesday, so I'll just quickly ask.

Briefly, we had a discussion. I know my colleague talked about the opiates and he announced a strategy a few weeks ago. I have to ask—you know what the limitations of private members are. We can propose ideas without any added cost. So with consultation from law enforcement, knowing that there are two real sides to this

opiate crisis—the legitimately prescribed opiates that are being redirected to the street, and then there's this counterfeit opiate business—I had a bill that I put forward, the Illegal Pill Press Act, that would actually allow law enforcement to access warrants and charge those who are in possession of a pill press and who are using it to manufacture counterfeit opiates that are frankly on our streets killing people. You announced and talked about in your answers testing strips that can test for fentanyl or other substances. Of course, it's an important measure. I agree with it. It's perhaps a simple and small step, but an important one. You did refer to my initiative as being over-simplistic. Why do you think that that is?

Hon. Eric Hoskins: I think I characterized that it would be over-simplistic to believe that that single measure would have a material impact, a significant impact, in terms of the crisis that we're facing. Individuals in this province are dying, at least, at the rate of two a day.

Mr. Michael Harris: Sure. Absolutely.

Hon. Eric Hoskins: The preponderance of investment—if that's the right word—that we need to make to reduce the level of crisis and hopefully eliminate it has to take a harm reduction approach.

Mr. Michael Harris: You mentioned—of course, I just want you to know. You talked about the federal initiative to ban the importation of pill presses. You would now hopefully appreciate the difference between what I was proposing on possession and importation being two different things. Do you understand that—

The Chair (Ms. Cheri DiNovo): I'm afraid, Mr. Harris, your time is up. Now we move to the third party: Madame Gélinas.

M^me^ France Gélinas: It goes by fast, eh?

Mr. Michael Harris: Too fast.

M^me^ France Gélinas: I want to read a few things into the record that we got through freedom of access to information from Peterborough Regional Health Centre. Earlier this month, on October 4, to be precise, Peterborough Regional Health Centre announced that it will open a permanent unfunded 24-bed medicine unit to deal with the overcrowding pressure that they are facing. Quoting from their document, under "Funding," it says, "Anticipated annual cost of operating the 24-bed medicine unit: approximately $4 million." And "Opening 24 new medicine beds this year will require the hospital to divert funds from this reserve.

"In future years ... we may not be in a position to continue providing these additional beds without diverting funds away from other hospital programs and services."

Peterborough has 414 beds. They have opened up, on their own, 24 more. They are now at 438 beds. On October 24, you announced 20 beds for Peterborough Regional Health Centre. I'm just a little bit curious: They had made it clear that they needed 24. They went out and opened them, although it was unfunded. The MPP for Peterborough made it clear that they will receive $1.37 million as part of your $100-million announcement, which is short of what they said they needed for this year, which was $1.8 million, and short of the $4 million that they will need on an ongoing basis. So the first question is: Why not 24?

Hon. Eric Hoskins: You're correct that on Monday I announced the addition of 20 acute care beds for Peterborough Regional Health Centre. I would say the figure that you used for 24, the annualized cost to the hospital, I think, is reasonably consistent with the approximately $1.4 million that we're allocating this fiscal year. If you think in terms of November, December, January, February, March—a five-month period—I think that the level of our investment is consistent with what you mentioned.

But to your comment about why 20 and not 24, we have an additional—

Dr. Bob Bell: Twenty-eight.

Hon. Eric Hoskins: —28 unallocated beds available to be allocated within that LHIN, so it provides us with the opportunity to allocate those within the LHIN context where we feel that need is most present.

M^me^ France Gélinas: So what would Peterborough Regional Health Centre need to do to get funding for their 24 beds, not 20?

Hon. Eric Hoskins: We're working with the LHINs, so that's an allocation that we provide to each of the LHINs to work, in concert with the Ministry of Health, with the hospitals that they have within their boundaries. As I mentioned, it provides the opportunity, and the intent is there, to further allocate based on capacity challenges, and as we get closer to flu season as well. The opportunity exists, and I would encourage it, for each of the hospitals within the LHIN, including Peterborough, to continue that conversation—which, no doubt, they're already having—with regard to how that additional allocation might occur.

M^me^ France Gélinas: They made it clear when they made their announcement that they were opening a permanent new unit of 24 beds. The money that you've announced is running out on March 31. You could see that there's a bit of anxiety in the air as to what will happen on April 1. When will they know what happens on April 1?

Hon. Eric Hoskins: Again, they're well aware that this is a normal budgetary process that we go through on an annual basis with them—rather, with Treasury Board and finance, and in concert with our hospitals and our LHINs, to determine what allocations are required for those in the hospital system. So this isn't unusual, and they'll be aware of that, particularly when it pertains to the new, in-year funding that this represents.

That work has already begun, which is a normal approach that government takes, and virtually every ministry within it, to have that discussion and deepen that discussion, not only with our stakeholders and partners in the LHINs but within government, with Treasury Board and finance, as we work towards a budgetary process that will provide an allocation.

M^me^ France Gélinas: So—

Dr. Bob Bell: If I may, Minister—

M^me^ France Gélinas: Go ahead.

Dr. Bob Bell: Another feature—sorry, Madame Gélinas—with respect to Peterborough is that they had a substantial budget surplus the year before, so perhaps opening those beds responds to a perception that they need to provide more care to the community and they have the budgetary capacity to do so.

Hon. Eric Hoskins: And we provided them, I think, with an additional just over $4 million in funding this year as well.

I think it's fair to say, Deputy, that we don't fund beds directly. We fund the operations of a hospital, and it's up to the hospital to allocate those funds provided to them in the manner that they believe best serves the needs of that community.

1750

M^me^ France Gélinas: But in their agreement, they all have a number of beds. All of the hospitals that I mentioned to you—the 414 beds, and the other one—those are all in the agreement that you signed, to transfer them the money. Where is the disconnect?

Dr. Bob Bell: If I may, Minister: The primary indicator of activity in the hospital is related to weighted cases as opposed to beds required to provide those weighted cases. If a hospital is able to—through various efficiencies, investments in community care, discharging planning etc., the things you know very well—discharge patients faster and don't need that number of beds, we're delighted if they're able to invest the money in other ways.

At the same time, running a surplus, as they did in 2016-17—I've had conversations with their CEO, who thought they may need to open another unit. I think that's the direction they've gone in.

M^me^ France Gélinas: Here again, I'm quoting from Peterborough Regional Health Centre's FOI that they sent to us. They say, "Any surpluses generated"—they agreed that they had one, and they said, "We generated a surplus last year," but they go on to say, "Any surpluses generated are earmarked for upcoming investments in hospital capital and infrastructure," so it kind of feels that they are trying to generate those surpluses so that they can meet their capital infrastructure needs. If they use this for operations, then how are they going to pay for capital infrastructure?

Hon. Eric Hoskins: That's a determination that the independently governed hospitals make on a regular basis, in terms of how they manage their operational budget and how they manage any capital challenges that they might face.

M^me^ France Gélinas: Okay. I will move to Mississauga.

We're talking about Trillium Health Partners, which operates Mississauga Hospital, Credit Valley Hospital and Queensway Health Centre in Toronto.

Here again, the FOI that we filed from Trillium Health Partners reads as follows: "109% capacity and 85 surge beds in use, including nine in unconventional spaces in January; 107% capacity and 80 surge beds in use, including eight in unconventional spaces in February; 104% capacity and 54 surge beds in use, including six in unconventional spaces in March; 103% capacity and 62 surge beds in use, including nine in unconventional spaces in April; 106% capacity and 59 surge beds in use, including seven in unconventional spaces in May"—and the list goes on.

You announced, on October 23, an additional 72 beds at Trillium Health Partners. Which hospital in the GTA is the most overcrowded right now, and where do you expect—yes, let's start there—where do you expect those 72 beds to go, allocated to Trillium Health Partners?

Dr. Bob Bell: Thanks for that question.

The 72 beds that we've allocated for the surge capacity at Trillium are going to be worked through with partners in the community. Using some beds that are in the new Oakville hospital or the Milton hospital is certainly a potential. There are unutilized beds in those newly opened hospitals. We're currently working through, with the CEOs of the two hospitals, how we could allocate additional space that would serve the needs of patients who are ALC, alternate level of care, at Trillium Health Partners. That's our current plan that's under way right now.

M^me^ France Gélinas: Trillium Health Partners has 1,254 ministry-funded beds—that's the language that they use in their agreement on their website and everywhere else. If you look at overcapacity, at 108%, 109%, 107%—I'll let you do the math—they're operating over a hundred beds over that 1,254, and you're offering 72.

Hon. Eric Hoskins: Can I correct you on that?

M^me^ France Gélinas: Sure.

Hon. Eric Hoskins: Because in the last three months of bed census data that I have before me, Trillium has been under capacity for each of those three months.

M^me^ France Gélinas: Which three months do you have?

Hon. Eric Hoskins: July, August and September.

M^me^ France Gélinas: What capacity do you have for July, August and September?

Hon. Eric Hoskins: It's less than 100% for each of those three months. Furthermore, I've—

M^me^ France Gélinas: Where are they at for those three months?

Hon. Eric Hoskins: Under capacity.

M^me^ France Gélinas: I mean what is the percentage?

Hon. Eric Hoskins: Less than 100%.

Dr. Bob Bell: The other thing I can add is that in addition to the 72 beds that we've been able to provide with the help of our partners, we've also invested in 22 so-called "bridges spaces," which are community spaces with enhanced home care being anticipated for patients with intense needs who have homes in the community they can go to. In addition, one of the things that has really been a problem at Trillium—as you know, they have a spinal cord unit there. They do have patients who have spinal cord injuries who have continuing need for ventilation. These patients will take an awful lot of capacity at the hospital, both fiscal capacity and they simply stay forever.

We've been able to create five new ventilation beds at West Park hospital. We think that moving those patients out, in addition to the 72 beds, in addition to the 22 bridges beds, these five vent beds plus additional beds in the Mississauga Halton LHIN—we've got an additional 45 beds that are allocated for potential use in the LHIN, with the ability to look and see how these initial investments work, and then allocating further beds.

M^me^ France Gélinas: So if we look at this region, Mississauga, Peel region, they are growing fast. We all know that. Do we have a plan, like a five-year, 10-year, 20-year plan to see how many additional beds, how many additional resources does Mississauga need? How many new hospital beds does Brampton need? Where is this planning being done?

Hon. Eric Hoskins: We definitely have a plan. If you'll allow me, just to finish on the deputy's comments. What he described is in addition to a just barely under $15-million increase in allocation this fiscal year to Trillium. The press release that was issued by Michelle DiEmanuele, the president and CEO of Trillium Health Partners, yesterday, quoting her, "We welcome the government's support which will directly benefit our patients and assist in addressing our significant capacity challenges. We have taken immediate action and assembled a team to expedite a plan for the new beds."

Quite apart from the investment that was announced this week, which includes Trillium, we—of course, the Premier, recently, together with myself and the finance minister—announced approval for building a new hospital on various sites in terms of the construct of that, which is obviously part of our capacity planning and response to what we would agree with in terms of this being an exceptionally high-growth community with increasing needs.

M^me^ France Gélinas: So you agree with the CEO when she said that they had capacity challenges?

Hon. Eric Hoskins: Well, I agree with you when you say that it is an area of the province of high growth. That's reflected. It's one of the highest-growth areas of the province and so that is resulting in increased visits to the ER. Naturally, a subsection of those visits will require admission. I think we would agree that one of the very specific challenges that Trillium and others that region face, is us, together, effectively managing the fact that it is in a very high-growth area.

M^me^ France Gélinas: Minister, you have quoted that July, August and September were all at below 100% capacity. Would you be able to share those in writing with the committee, so that I see exactly what it is? Because if I'm getting different information than you, that always worries me.

Then if there are plans under way, is there any way you can share a bit of what this looks like, so we can give people reassurance that the ministry understands that this is a high-growth population, that they have a plan and here's what is taken into account into this plan and share that with the committee?

The Chair (Ms. Cheri DiNovo): That concludes our time for today. This committee stands adjourned until next Tuesday at 9 a.m.

The committee adjourned at 1800.

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