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Thursday 2 March 2006

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Jeudi 2 mars 2006

Standing committee on public accounts

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Auditor General:
Ministry of Health
and Long-Term Care

Comité permanent des comptes publics

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ministère de la Santé
et des Soins de longue durée

Chair: Norman W. Sterling
Clerk: Susan Sourial

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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON PUBLIC ACCOUNTS

Thursday 2 March 2006

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DES COMPTES PUBLICS

Jeudi 2 mars 2006

The committee met at 0946 in committee room 1, following a closed session.

2005 ANNUAL REPORT, AUDITOR GENERAL

MINISTRY OF HEALTH AND LONG-TERM CARE

Consideration of section 3.02, land ambulance services.

The Chair (Mr. Norman W. Sterling): Deputy, perhaps as we're handing out copies of your opening remarks, you could introduce the people with you. Then I would invite you to make your opening remarks.

Mr. Ron Sapsford: Chair and honourable members, it is my pleasure to be here today in response to the annual report of the Auditor General on Ontario's land ambulance program.

Joining me today are two of my colleagues from the Ministry of Health and Long-Term care, each of whom has considerable and detailed knowledge about this particular program of the government. Mary Kardos Burton is the assistant deputy minister of the acute services division of the ministry. She is here accompanied by Malcolm Bates, on my right, director of the division's emergency service branch, which is responsible directly for the land ambulance program. Mary Kardos Burton will present a prepared statement in a few moments. Then she and Malcolm Bates will make every effort to answer further questions you might have concerning the land ambulance program.

I speak for my colleagues here today, and the many other people who are responsible for delivering land ambulance services across the province, when I say that we welcome the findings of the Auditor General.

Unquestionably, the issues surrounding the provision of land ambulance services in Ontario are complex. However, let me stress that the ministry has a steadfast commitment to ensure that the highest standards, performance and accountability are maintained in the provision of these services.

Furthermore, the Ministry of Health and Long-Term Care and the municipalities share the common commitment to improve the delivery of excellent, affordable and timely pre-hospital health care services. I'm pleased to note that this commitment was recently reinforced by the government when it announced on February 21 that it will spend an estimated $300 million more over the next three years to achieve the 50-50 funding of costs for municipal land ambulance services. The target for closing the gap in costs in provincial funding is 2008.

As you know, under the Ambulance Act, municipalities and district services boards are responsible for the provision of land ambulance services within their jurisdictions and can modify services to meet their emergency response needs.

The Ministry of Health and Long-Term Care has a monitoring and regulatory role in the delivery of land ambulance services. This role reflects the ministry's shift toward being a strategic manager and steward of health care programs. In this new role of planning for and making wise use of our resources the ministry will be responsible for:

—establishing overall strategic directions and provincial priorities for the health system;

—developing legislation, regulations, standards, policies and directives to support these strategic directions;

—monitoring and reporting on the performance of the health system and the health of Ontarians; and

—planning for and establishing the funding models and levels of funding for the health care system.

In closing, let me stress that what won't change is the ministry's uninterrupted commitment to a level of service that stands up favourably to any and all scrutiny.

I'm now pleased to introduce Mary Kardos Burton, who will address directly the Auditor General's recommendations.

Ms. Mary Kardos Burton: Thank you very much, Deputy. It's my pleasure to join you today and to answer any questions the committee members may have concerning our province's land ambulance program, its operation and its expenditures. First, though, I'd like to provide you with a brief background about the program in Ontario.

Provincial funding for the municipal provision of land ambulance services is provided through an annual land ambulance services grant covering 50% of the approved land ambulance costs under a cost sharing agreement. As well, Ontario provides 100% of the approved costs for the delivery of land ambulance services to First Nations communities and territories without municipal organization.

Let me give you a few statistics to illustrate the scope of land ambulance service in Ontario.

Land ambulance services employ more than 1,000 ambulances, more than 300 support vehicles and more than 400 ambulance stations across the province.

Some 6,800 land ambulance paramedics and 800 ambulance communications officers handle more than half a million emergency and non-emergency inter-facility ambulance calls annually. These facilities include hospitals, long-term-care homes and medical offices. In all, more than 1.5 million requests for ambulance services were processed in 2004-05.

Now let me address the auditor's specific comments and outline the ministry's response to each one.

Responsibility for land ambulance services: First, the Auditor General has recommended that the ministry assess what is needed to ensure seamless, accessible and integrated land ambulance services regardless of municipal boundaries.

In response, let me say that this is an essential principle that is shared by the ministry and the municipalities through a memorandum of agreement. In emergencies, ambulance dispatchers always send the closest and most appropriate ambulance, which is consistent with the legislated responsibility of the municipalities to provide the services needed by people in their municipalities.

A land ambulance committee with municipal representation was formed in October 2005. The formation of this committee follows through on the province's commitment that, as part of the strong communities initiative, it would convene a municipal-provincial consultation committee to discuss municipalities' concerns related to land ambulance services and delivery. The land ambulance committee will be reviewing its advice related to this and, indeed, to a number of other recommendations made by the Auditor General concerning the ambulance program.

Second, the Auditor General noted that in the previous audit of emergency health services published in the 2000 Special Report on Accountability and Value for Money, the ministry was advised to work jointly with municipalities and the hospital community to develop and establish standards for non-ambulance medical transport services to address passenger safety; and to work towards the most cost-effective resources for the scheduled transfer of non-emergency patients. In response, the ministry appointed a lead to transform Ontario's medical transportation, and we've had people working on that since that time.

Response times: The Auditor General has made a number of recommendations concerning emergency response times. Recommendation one advises that the ministry and municipalities review current response time requirements for reasonableness and consistency and adjust where needed. Recommendation two advises that the ministry and municipalities work in concert to meet response time requirements. In response to these recommendations, we expect that the review of the advice presented by the land ambulance committee will help us in determining the best option to work with municipalities on response time standards and performance.

The third advises that the ministry should assess the costs and benefits of a fully coordinated emergency response system that includes strategically placed, publicly accessible, automatic, external defibrillators. In response, the Ontario health technology advisory committee last year asked the ministry's medical advisory secretariat to conduct a health technology assessment and policy analysis of the various components of a coordinated emergency first-response system. This includes response times and use of automated external defibrillators to improve cardiac arrest survival. Recommendations on the settings in which the defibrillators are practical and cost-effective will be considered.

In the next recommendation under "Response times," the Auditor General has advised that the ministry should monitor dispatch centre performance throughout Ontario to ensure they meet the required reaction times. In response, the call processing time performance of dispatch centres is now being monitored on a monthly basis, and where such times are not meeting the standard, an assessment is conducted to determine why. Once that has been determined, measures, such as staff training and additional resources, are used to improve performance.

In his next recommendation under "Response times," the Auditor General advised that the ministry, in concert with municipalities and hospitals, should minimize situations where patients have a long wait in an ambulance before being accepted by a hospital. The Minister of Health and Long-Term Care established the hospital emergency department and ambulance effectiveness working group last year. The ministry has reviewed the group's recommendations, and on February 21, 2006, the government announced a $96-million action plan to reduce ambulance and patient wait times at hospital emergency departments. The plan calls for a collaborative effort between hospitals, land ambulance operators and other key stakeholders to reduce the impact of delays in hospitals accepting ambulance patients. The emergency department and ambulance quality implementation team will include chiefs of emergency medical services, emergency department clinical leaders and others. Ken Deane, president and CEO of St. Joseph's Health Centre, Toronto, has been appointed to chair this group.

Funding: The Auditor General recommends that the ministry and municipalities develop a better process to achieve a balanced and integrated system of land ambulance services. In response, the ministry review of advice submitted by the aforementioned land ambulance committee will include consideration of that recommendation.

The Auditor General recommends the ministry reassess its position on the size of municipal reserve funds allowed and consider, where warranted, third party or internal audit assurance on costs claimed by municipalities. In response, the ministry does monitor municipal spending, including reserves, to ensure that all related ministry funding is spent on land ambulance services. Based on how much money is needed for such future costs as vehicles and equipment, the ministry position is

that the accumulated reserves for most municipalities are reasonable. Where such reserves are large, the ministry obtains information on municipalities' expected use of the reserves and conducts follow-up, if needed, to ensure reserves are reasonable.

The Auditor General recommends the ministry and municipalities work together to facilitate inter-municipal billing to encourage quickest response time regardless of municipal boundaries. In response, it's expected that the ministry review of the land ambulance committee's advice will consider measures that relate to this recommendation.

Dispatch operations: The Auditor General recommended the ministry make a decision on its choice of dispatch protocols to help dispatch centres better respond to individual patient needs. In response, the ministry is evaluating one of many internationally used dispatch protocols as part of the Niagara Ambulance Communication Service pilot project, and will use this evaluation to make a decision on protocols.

The Auditor General recommended the ministry expedite its evaluation of the pilot project, particularly with respect to the issue of municipal versus centralized dispatch. The recommendation also advised that the ministry incorporate best practices and research from other jurisdictions in determining the right number, location and management of ambulance dispatch centres. In response, the ministry is committed to evaluating the Niagara pilot project in a timely manner and will use the valuable information to improve ambulance dispatch operations in Ontario.

Reviews: To better ensure that land ambulance service operators meet certification standards, the Auditor General made three recommendations.

First, he recommended that the ministry conduct a number of unannounced service reviews to increase assurance of consistent quality of practice by operators. In response, while the ministry does conduct unannounced spot performance reviews, in accordance with certification standards, service reviews of ambulance operators are announced in advance. This is because service reviews require a significant commitment of ambulance operator time and resources while the review team is on site. Conducting these reviews unannounced could disrupt the operator's delivery of services. In concert with municipal representatives, the ministry will review the certification standards and further assess the appropriateness and benefits of unannounced reviews.

In the next recommendation, the Auditor General advised that, when operators don't meet certifications standards, the ministry conduct the requisite follow-up service review and inspections on a more timely basis. In response, the standard is to send the draft review report to the operator within 60 days after the end of the review visit. The operator then has 60 days to respond to the review finding. Follow-up visits are then scheduled 60 to 90 days after the receipt of the operator response to the draft review report. The ministry will work with municipal representatives to review this standard to determine the reasonableness of conducting follow-up reviews sooner.

The Auditor General also advised the ministry to clarify when director's orders should be issued, and under what circumstances there should be formal consideration of revoking the operator's certificate. In response, director's orders are reserved for infractions that have a direct bearing on patient care or public safety, or when a municipality is seen to be consistently failing to comply with legislation, or is failing to follow up on the recommendations of a service review. The ministry will review when director's orders or revocation of an operator's certificate should be considered.

To help ensure that land ambulance dispatch centres are effective and comply with ministry standards, the Auditor General made two recommendations.

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The first recommendation advised performing periodic reviews of the centres' operations, including a review of a sample of calls to determine whether they are handled and prioritized appropriately. In response, dispatch centre staffing has recently been stabilized, and a prototype service review has been piloted. A regular review of dispatch centres is being conducted with the goal of reviewing six or seven centres annually. The review process for dispatch centres includes a call sampling tool for reviewing call priority and management by call takers and dispatchers.

The second recommendation advised the implementation of a standardized quality assurance process to monitor and assess the overall operational performance of all dispatch centres and the individual performance of dispatchers. Such a process has been developed, and a pilot has been in place in four dispatch centres in eastern Ontario since last spring. The final quality assurance program will be implemented in all centres this month, March.

Base hospitals: To better ensure that paramedics provide quality patient care, the Auditor General recommended the ministry determine the optimal number and distribution of base hospitals which train, certify and provide medical direction to paramedics. The ministry should also ensure that base hospitals adhere to consistent standards in such areas as quality assurance and the continuing medical education of paramedics. A review has been conducted on the delivery of base hospital program services and has recommended consolidation of base hospitals.

Complaints and incidents: To help ensure that recurring potential problems are identified as soon as possible, the Auditor General advised that the ministry and the municipalities jointly develop and implement a process to ensure that the ministry receive adequate information on the nature and resolution of the more serious complaints made about land ambulance services. In response, ministry and municipal officials have agreed on an investigations protocol that addresses the operational practices of both parties when handling such complaints. Further consultation is scheduled to improve

compliance with the reporting requirements in the legislation and the protocol. As well, the ministry will continue to track investigations and their follow-up, and assess the type, nature and frequency of all complaints.

Performance measurement and reporting: To help ensure that ambulance services are accountable, and to support continuous improvement in services, the Auditor General recommended the ministry and municipalities establish pertinent performance measures such as response times, and report publicly and regularly on these measures. In response, it's expected that the ministry review of the land ambulance committee's advice will consider measures that relate to this recommendation.

That concludes the ministry's responses to the Auditor General's recommendations.

In closing, let me stress that what won't change, as the deputy said, is the ministry's uninterrupted commitment to a level of service that stands up favourably to any and all scrutiny.

The government further demonstrated this commitment on February 21 this year, when it announced that it will be spending an estimated $300 million over the next three years to achieve a true 50-50 sharing of the cost of municipal land ambulance services by 2008. With this commitment, municipalities and delivery agents will be better enabled to meet the fiscal challenges they currently face in regard to the proper provision of land ambulance service within their jurisdictions.

I appreciate your kind attention today, and now my colleagues and I would be pleased to answer questions you may have, either today or in written form. Thank you very much.

Mr. Sapsford: Just one point: Mary Kardos Burton has another commitment and will be leaving and then coming back to the meeting, just so that you're aware.

The Chair: Okay. That's fine.

Can you just clarify the new announcement? There's been some confusion with regard to the 50-50 being based upon what will be the cost in 2008. Is that the commitment, or is the commitment of 50-50 on the basis of a benchmark year of 2003?

Mr. Sapsford: It was based on an estimate of costs scheduled forward, but I want to make clear that the absolute dollars are the working pool that the ministry has. So we'll be working with municipalities to ensure that costs of operation are, in fact, maintained within the allocation that we have.

The Chair: So to reach 50-50 now, how much would it take per year?

Mr. Sapsford: The estimate in terms of the dollars that are made available will take us toward that in 2008, I believe was the number.

The Chair: You have $300 million, but are you estimating that the numbers in 2008 will mean that you are in fact sharing 50-50—50% of the 2008 costs as they will be then? Is that what the $300 million—

Mr. Sapsford: That's what the estimate is, yes.

The Chair: Okay. But today, just to get 50-50 in this year, what would it take?

Ms. Kardos Burton: It depends on how you look at it. The projection is to get to 50-50 in 2008. There isn't an intention to necessarily get to 50-50 this year, but our estimates have been in the $80-million to $100-million area.

The Chair: So it would take $80 million to $100 million to hit it now?

Ms. Kardos Burton: Yes.

The Chair: Okay. The $300 million, is that your contribution as you scale up, so it's a cumulative number, or is $300 million the number you'll hit in 2008?

Ms. Kardos Burton: It's over $300 million in 2008. It will take $300 million to reach close to the 50-50 standard based on our current projections in 2008.

The Chair: So the spread will go from $100 million—

Ms. Kardos Burton: Up.

The Chair: Did you have a supplementary on that particular question, or do you have other questions?

Mr. Richard Patten (Ottawa Centre): No; other questions.

The Chair: Okay. Shelley first, then.

Ms. Shelley Martel (Nickel Belt): Thank you for joining us. Thank you to everybody who's here. I want to start in the context of understanding what that will do to response times. I was on that committee in 2001 as well and I'm seeing a lot of these things again.

My concern is that essentially the auditor's report this time showed a worsening situation in about 44% of municipalities with respect to response times. The government has made an announcement that, by 2008, we hope to get to a 50-50 cost share, but we know right now that 44% of municipalities have a worse response time and that's a 1996 response time, so it's 10 years old. What is this $300 million going to do with respect to dealing with response times, (a) to ensure that municipalities are actually meeting the legislated response times, and (b) to make sure that the response time is more appropriate? This is 10 years later. I have to assume that in some communities the response time that's in place is not appropriate anymore for the population. Can I start with that?

Mr. Malcolm Bates: I think you've got a couple questions there that probably require answering, as usual. I know you weren't here last week, Ms. Martel, but we utilize these—

Ms. Martel: I'm sorry I missed you.

Mr. Bates: —to assist comprehension of what's going on. You're absolutely right. You've heard of ambulance chasers; we all have. Municipalities generally tend to be response time chasers, but they're serious about it, and here are some of the headlines that in fact we've looked at over the past few years from across the world, because the Auditor General, as I know you know, looked at not just Ontario but other jurisdictions.

We'll find that, for instance, "Local Paramedics Need Timely Improvement," from Ottawa. We see "Ambulance Response Time Improving," from Stratford, and "Ambulance Crews Face Faster Response Demand,"

from the BBC. In England, "Sweeping Improvements to England's Ambulance Service Required."

Here's where we get a little bit serious: "One Suspended in Ambulance Probe: A member of staff in the Wiltshire Ambulance Trust was suspended over figures for response times," again from the BBC. "Local EMS Cited as Being Slow," "Inquiry into Ambulance Services," "Ambulance Missed Response Time Goals," "Ambulance Services Accused of Fiddling."

It's very important as far as municipalities go. It's something we also take very seriously.

Let's have a look at Ontario. This is what you're after. Here are the 1996 standards that were referred to for each municipality. You can see the differential; in fact, differential between one area and another. That may seem close in the sense of characteristics of geography, population and so on. These are 1996 standards. They were based upon what the operators in 1996 in those particular jurisdictions achieved. I hope you can see. We go, for instance, from 10 minutes and 48 seconds in Niagara; 15 minutes in Haldimand; nine minutes in Middlesex; 15 minutes and 54 seconds in Grey; 19:57 in Bruce; Parry Sound, 27 minutes and 57 seconds; Nipissing, 13:32; the city of greater Sudbury, 12 minutes and 11 seconds; 21 minutes in Kenora. So we can see a great variation in response time standards as they now exist. You're absolutely right: They don't take into account the things that have changed since 1996. They don't take into account local characteristics. Those are the sorts of things we have to look at.

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Let's look at those that are meeting the 1996 standards. The green are meeting the 1996 standards. This is what the Auditor General pointed out. There are a lot of them that aren't meeting those particular standards. There are a few in the north that are meeting the standards that are presently in effect, but you can see the predominance is that they're not meeting those particular standards. But how far away are they? If you put the response time within two minutes of the 1996 standards, there are only a few that are not close to those 1996 standards. In fact, the predominance is that they would in fact be very close to the 1996 standards.

I think it's important to look at the principles of response time standards, because that's what it's all about. This is the National Association of EMS Physicians, a pretty skilled group of people, establishing their principles of response time. Here's where we, in fact, are adhering to their principles or not. For instance:

—They define the elapsed time for an EMS dispatch notification to the time of arrival at the scene: Well, we're okay with that one; that's part of our standard.

—Response time should realistically assess the resources and attributes of a community: Uh-uh, we're not there because we're looking at 1996 standards. Just like you said, that's not what we're doing at this particular point in time.

—Fractile response intervals: That's what we do.

—Medical directors: We have a different system because we utilize base hospitals rather than individual medical directors for municipalities.

—Prioritize the calls based on severity: Of course we do that.

—Assessment of response times should be ongoing and change should be incremental: We haven't looked at them since 1996. In fact, we didn't even look at them in 1996; we just used what was there in 1996.

—Response times will vary by community: Well, they do. We saw that rate variation by community.

—Medical necessity and community expectations must be weighed: Of course we do that.

—The plan should recognize non-traditional responders: That means automatic external defibrillation-equipped police, fire and other types of people. We don't do that. Our standards do not recognize the utilization of that type of first responder with AEDs.

Ms. Martel: I appreciate all that, but—

Mr. Bates: We're getting somewhere.

Ms. Martel: Yes, because I've got lots of questions, and these are important issues. But what I want to know is, you announced $300 million; you hope to have a 50-50 cost share by 2008. What is that going to mean for response times? Are municipalities actually going to be meeting their legislated response times by then? Are the response times going to be different to take into account some of these changes?

Mr. Sapsford: You're looking for a direct correspondence between the money and the standard improvement.

Ms. Martel: Well, I'm hoping, and I'll tell you why, Deputy. The auditor tells us that costs have increased by 94% over the last four years to provide ambulance services, and yet in his most recent report, two thirds of municipalities are not meeting the 1996 standard and 44% of those municipalities are in a worse position. So we're going to add more money to the system. That's great, because I recognize in my community, in my DSSAB, it's not 50-50. But surely some of this money is going to translate into actually meeting some legislated response times, so we're not here two years from now with an even worse situation in most municipalities.

Mr. Sapsford: With an increase in the funding and an easing of the current fiscal pressure on land ambulance services in municipalities, the intention of the ministry is then to complete this discussion with municipalities and, as Malcolm is illustrating, begin to apply some of these criteria to a redefinition of response times. From there, the ministry's role in terms of monitoring and management will be to move response times to an improved basis. So the direct correspondence between the money, I can't answer directly, other than to say that with the additional money it will allow us to move forward with the discussion and, one would conclude, improvements in performance.

Ms. Martel: So at this point in time, those discussions are going on at this committee. You are not in a position

to tell us where we might end up. I think that's the best way to describe it. You're hoping.

Mr. Sapsford: In quantitative terms, not at the moment.

Ms. Martel: When do you expect, then, that we would have a better understanding of what appropriate response times are for municipalities?

Mr. Sapsford: I would expect over the course of this year.

Ms. Martel: And that information will be released publicly?

Mr. Sapsford: Well, yes, the response times for ambulances will be.

Ms. Martel: You don't know what that's going to be yet, but you have set aside $300 million, which you hope will represent a 50-50 split. So is there a possibility that, in fact, your estimate is wrong, because we don't actually know what response times we're moving toward at this point in time? I mean, your estimate could be wrong. It could be less than that, what you might need; it could be significantly more than $300 million by 2008. Would that be correct?

Mr. Sapsford: Estimates are estimates. We will continue to monitor and move forward on this. I mean, that's the nature of the business we're in, but this is a good start in moving in that direction. So as I've said, the ministry's ongoing role will be to work with the municipalities and to begin to move the yardsticks on response times as a result of it, but we'll have to continue to monitor that over time, and if adjustments have to be made, then we'll look at it.

Ms. Martel: The committee is looking at a number of things. Do you expect they will have staged recommendations, or are we going to see all of these recommendations at the same time?

Mr. Sapsford: No, probably all at the same time. One of the going-in principles is that we look at all aspects of it. So the process of the committee was a series of working groups, and the topics were split down. Those working group reports will come back for a central discussion so that the work will be completed roughly at the same time.

Ms. Martel: Our note said spring of 2006. Is that still on schedule?

Mr. Sapsford: Correct.

Ms. Martel: So spring is June? April? Somewhere in there?

Mr. Sapsford: April, May, June.

Ms. Martel: Okay. Let me look at some of the other things that were referred to the committee, because I said at the start that one of my concerns was that we're seeing many of the same issues that were dealt with in the 2000 report and reported on by the public accounts committee in 2001. They were issues that were being looked at by a previous municipal ministry working group, at that time called LAISC, which I understand was disbanded in 2003. So some of these issues never went forward again.

Part of the concern that I have is, despite that, there were recommendations that had been made by various groups that I would have thought could have been implemented, even as this working group continues its work. So can I just deal with, for example, the non-emergency schedule of transfers.

There was a May 2004 report of the land ambulance acute transfer task force that recommended that regulating medical transport services was the minimum required action to ensure patient safety. They called for a new provincial regulation to ensure patient safety. That was a recommendation that was also made by a consultant's report that was commissioned by the Ministry of Health in 2002. You're telling us that that issue is now being discussed by this committee, but since we've already had two recommendations for regulations, one in 2002 and one in 2004, why is it that we cannot move forward on at least some regulations regarding medical transport services to have that under way? Why did that issue go back to this committee when we've now had two separate reports that recommended provincial regulations to ensure patient safety?

Ms. Kardos Burton: I'll start in terms of responding to that. In the group that the working groups are doing right now, our mandate was to look at a number of the things over the last few years that have been irritants to municipalities and some to us as well. So we had a mandate to look at system improvements. This is one of them, as were the response times, which you mentioned earlier, and the inter-facility transfers and cross-border billings.

The positive thing is that we all agreed on the things. We and the municipalities agreed on the things that were kind of top priorities that we needed to look at. So the expectation would be that when we complete our work, when it's taken forward to government, when it's approved, the non-emergency part will be addressed at that time, but we were given a mandate to look at the whole system.

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Ms. Martel: I think you've named four—and I think I've only picked up two—items that were of most concern. So can you just give—

Ms. Kardos Burton: Response time, inter-facility transfers, cross-border billing—

Mr. Bates: Payment schemes.

Ms. Kardos Burton: —payment schemes, which I didn't mention, but Malcolm has for me.

Ms. Martel: Is the use of regulations still part of the discussion on the transfers, the use—

Ms. Kardos Burton: The method of what we'll use is part of the discussion. So it could be that, it could be other ways, but it is part of the discussion.

Ms. Martel: Let me just back up a little bit, because I'm not sure I understood "method of what we'll use." "Method being" which type of transfers would be most appropriate in which cases?

Ms. Kardos Burton: I actually meant regulation or non-regulatory. It's under discussion.

Ms. Martel: So even though there were two recommendations made, it's not clear that that will be the

outcome, that regulations will be the way the ministry is going to proceed?

Ms. Kardos Burton: Correct.

Ms. Martel: Would there be a reason for that, especially after two reports that recommended regulations?

Ms. Kardos Burton: There would have to be a reason for that if that's the outcome.

Ms. Martel: Can you share what the thoughts are of the committee around that then? Is that a fair question?

Mr. Sapsford: It's a fair question.

Ms. Kardos Burton: Yes, it's a fair question.

Mr. Sapsford: Not being familiar with the previous reports but more with this discussion, I think the focus of this discussion is on the actual implementation as opposed to what are the issues and what we are going to do. So the discussion is very much focused on how do we implement the changes, and in that discussion with municipalities, the subject matter of what's on the table is different. It may be that on some of these inter-facility transfers, we can do many of the things by policy, but it may mean that we must do some things by regulation, where we want the ministry's inspection functions or follow-up functions to be front and centre. It's not so much an either/or; it's which issues suit themselves more to the regulatory framework as opposed to what's more of a normal operational policy position.

Ms. Martel: The other item that you're dealing with, the cross-border billing, was one that was identified by the ministry, but it's one that's been identified in our community for some time with our district social services admin board. In a letter that I had done to the minister in May 2005, I pointed out that at that time the issue was costing our DSSAB about $1.5 million. That takes in some of my riding and it takes in some other ridings. But it's not a large area, and it's got lots of small municipalities that aren't very wealthy and a number of non-organized municipalities. What they said very clearly to me was that part of the reason this issue continued is that, frankly, they didn't trust the ministry's data with respect to cross-border issues. Is concern about the ministry's data being raised at the table again, and then what is the ministry doing to respond to that concern that I have at least heard from my local people?

Mr. Sapsford: The whole issue of cross-boundary billing is a complicated one. Some of the discussion went right back to the beginning in the sense of, should we have it at all? To me, the discussion is, which perspective are we going to take on it? I'll give you an example. The costs among municipalities vary. If an ambulance from a municipality that has a higher cost structure is working in one that has a lower cost structure, from that municipality's perspective it's costing them more for ambulance services than it costs for their own service, so there's a resistance to paying the bill.

The responses to that are two: "We can't afford to pay the bill," or "The ministry should adjust the difference so that we can pay the bill." As soon as you enter into that kind of discussion, it raises the question, should we be doing cross-border billing at all and trying to even the playing field and deal with cross-border ambulance services through the global granting or the general funding system? This has been the nature of the discussion. They're not very easy discussions, but I hope that at the end of this discussion with municipalities we'll be able to resolve it one way or another.

Because there is variance in the costs across the province for providing ambulance services, it gets into the situation of, "Do I pay more or do I pay less?" The ministry is going to have to try and find an acceptable way where we can get the largest consensus among municipalities.

Ms. Martel: Okay. I appreciate that response.

Mr. Sapsford: That would then address the question you're raising. One of your municipalities, obviously, is on the wrong end of that stick, from your perspective. As soon as you get into that discussion, issues about data become increasingly important because it becomes a per call charge. We're trying to look at different ways of handling the cross-border service issue, rather than just sticking on, "How much am I going to pay for a cross-border call?"

Ms. Martel: Can I reinforce how important it is to have some kind of positive resolution? I'm sure you're hearing that at the tables, but if I just look at Manitoulin-Sudbury DSSAB, their estimate of what they were owed for the services they had delivered was $1.5 million. That was just between 2001 and 2003. My anticipation—I don't have the more recent numbers; I apologize for that—is that I suspect the money owed to them is even greater. This is a DSSAB that has municipal structures that are not wealthy, that are small, that have a very small tax base in a number of unorganized municipalities, with costs that are picked up by the province, but a year later—I'm going to get to that in another round of questions. This is a really significant issue for them and I suspect a number other DSSABs in northern Ontario in particular, not to mention smaller municipalities, rural municipalities.

Mr. Sapsford: We do recognize that.

Ms. Martel: Okay.

Mr. David Zimmer (Willowdale): Just two questions: You've got some ambitious plans. You addressed these various issues. How do you see the plans and the future of this issue interacting with the LHINs, which of course are sort of decentralizing health care management? Ambulances obviously have to at least interact with that whole LHINs structure out there, whether it's in the hospitals or long-term care, or all of the other aspects. Given that the mandates of the LHINs, or the expectation of the LHINs, is that there's a concept of decentralization and so on, how is that concept of decentralization of some of these health care management issues sort of mixed with the plans out of the ministry to keep a much closer grip on this land ambulance issue playing out? How's that world? What's your vision of that new world?

Mr. Sapsford: The role of the LHINs with respect to land ambulances is outside the fiscal and allocation authority of the LHINs, but at the local level the LHINs

also carry a planning responsibility for the health system as a whole. We fully expect that ambulance services, being a critical part of the health system response, will be engaged with LHINs in the operational and service planning for the future. For issues that touch on hospitals, such as emergency overcrowding and some of the issues there, as the LHINs begin to start these discussions with their local service providers, municipal ambulance services would be at that table looking for solutions. Their role with land ambulances would be at that planning, resource need assessment, as well as operational coordination and planning.

Mr. Zimmer: From your point of view, what difficulties, if any, do you see that world fraught with in terms of your mandate?

Mr. Sapsford: In terms of our mandate? I don't see any particular problems. I think our mandate deals more specifically with the quality of ambulance services and the benchmarking and some of the other issues that have been identified. The ministry will continue to work directly with ambulance services on their specific performance issues. It may be that in local planning, LHINs will identify issues related to ambulance services that then, in their role with the ministry, we will pick up. So I view the partnership very much between the ministry and the LHINs as being a productive partnership to resolve issues.

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Mr. Zimmer: If an issue were to crop up between a LHIN and the ministry on an ambulance issue, given the mandate of the LHINs, who in your view would have the last word, or at least the more senior word, on an issue?

Mr. Sapsford: On ambulance specifically?

Mr. Zimmer: Yes.

Mr. Sapsford: The ministry will be in the lead on it, but we're going to have to be, as a ministry, quite sensitive to the local situation. So if a strong position is coming forward from a local community through the LHIN that there ought to be a change in ambulance policy, or whatever it happens to be, my position would be that the ministry must listen very closely to that. The whole approach behind LHINs is that the community itself needs to take responsibility for its planning and decision-making around that local system. So while the ministry still has the statutory and regulatory responsibility for ambulances, on the actual operation of the system, we have to listen carefully to the LHINs' recommendations.

Mr. Zimmer: Given that response, and I appreciate that response, how would you sort out an issue if it became apparent that LHIN A had ideas and needs and was pushing for concepts that were perhaps in conflict with a similar sort of push-back or needs in LHIN B, given that the LHINs are supposed to be sort of decentralized? How will you avoid the situation of having an approach for LHIN A and perhaps an approach for LHIN B? How do we sort that out?

Mr. Sapsford: In some cases, that's to be encouraged, in the sense that part of the thinking behind LHINs is that they are to instigate and encourage innovation. I don't pretend for a moment that the way the health system is currently structured and operated is the best we can do. The ministry wants to be in a position to encourage innovation and better ways to serve patients and citizens and communities. So part of our future role is not to be a brick wall in refusing to look at new ideas, but to be anticipating and encouraging new ways of thinking so that if a good idea comes up in one community that has general applicability across the province, part of the ministry's role is to be sensitive and to promote that kind of innovation.

I don't view difference—LHIN A wants to look at it this way versus another way—to be a negative thing. It needs to be balanced against provincial standards, because there are certain aspects of delivery where you want to have consistency across the province. But that's an evolutionary thing. As new ideas come forward and are adopted in one community, I'm anticipating we can take the benefit and improve the standard of service across the province.

Mr. Zimmer: So I take it there's room for both deference and differential approach to some of these issues vis-à-vis the LHINs?

Mr. Sapsford: That's correct, and that becomes our management challenge.

Mr. Zimmer: One last question, and this is sort of an observation, albeit anecdotal, on the huge cost of ambulance and so on: Just speaking personally, an anecdotal point of view, I have the sense that—we hear a lot about the misuse, for instance, of emergency wards; that is, people who go to the ER because they have a hangnail, and then that causes backlogs and costs and reportings and so forth and so on. I have the sense that there's somewhat the same phenomenon in the world of calling ambulances. I'm often in neighbourhoods or driving down the streets and I see, for instance, a fender-bender, and it can only be a fender-bender by anybody's kind of definition, and I see a police vehicle, I see a fire truck and I see an ambulance, and everybody is kind of milling about, and it turns out to be a fender-bender and everybody goes away.

I rather expect that kind of thing is repeated throughout the system in a big way—people calling ambulances or physicians calling ambulances—the misuse of the ambulance system, like the misuse of the ER system. It seems to me that one of the things we really need here is some sort of public awareness program or something that will make people less quick off the mark to call the ambulance, as we're working on this idea of making them less quick off the mark to trot into the ER.

To what extent is the overuse of ambulance services a factor in driving up the bad statistics?

Mr. Bates: There are a number of questions that you put there, and they're all very good ones. I understand you're from Toronto, because you're right up the street from our office. I pass your particular office on a regular occasion. What you're looking at in Toronto is Toronto's tiered response methodology, in which Toronto utilizes

fire and police for emergency calls. That's why you'll see in most instances—and I saw the same thing the other night going home from work. You'll see the first response vehicle, you'll see the ambulance, you'll see the fire truck and maybe the police. But that is their way of handling an emergency situation. It doesn't happen all across the province. There are, of course, tiered-response agreements in many municipalities, and that's good. The ambulance dispatch calls for a tiered response when required, and normally it's the fire department that arrives, because they are trained in first aid, CPR and defibrillation. So they will arrive on the scene usually before the ambulance. That's one of the things we were pointing out with respect to first responders, and we'll probably have a chance to show you a little more about that later. So it's a good thing for that to happen.

Whether the sort of thing you're suggesting in Toronto is overkill or not—maybe it is—that's a municipal decision and they have the resources to do it. I think they have assessed it on a number of occasions and probably found that's the best way they can handle it. The municipality handles the police, the fire and the ambulance. In other jurisdictions, they're different. As you know, the OPP are a different jurisdiction.

The other factor you asked about was utilization of the ambulance that perhaps may be inappropriate utilization. I'm not saying that doesn't happen—of course it happens. Calls come into the dispatch centres, but the dispatch centres have a very thorough screening process and they prioritize calls, from an urgent, life-threatening call to simply a non-urgent call where they can provide extra time for the ambulance.

There is an interesting experiment, if you will, that will be going on as part of the emergency department announcement that was made several weeks ago by the minister, and that is, in Toronto—again, we're in Toronto—to look at providing a caller who the dispatcher feels is not in a life-threatening situation with the number of TeleHealth, and in fact connecting them to TeleHealth to provide the type of service they need when it's not a life-threatening or urgent call that the ambulance needs to respond to. If TeleHealth can't help them and they think it is an ambulance call after all, then they will patch it back to the ambulance dispatch and the call will be handled by ambulance.

Another important aspect of that, I think—and it's something Ms. Martel referred to or alluded to—is the utilization of non-ambulance medical transportation providers across the province. These have increased considerably over the past five years, for various reasons. They are handling the greater percentage of transfer calls between institutions in the province at this particular point in time, the calls in which the patient is stable, doesn't require a paramedic, doesn't require a stretcher to handle it. Those particular medical transportation providers—and there are a lot of them now throughout the province—have in fact taken over 250,000 calls from the ambulance system that would in the past have been handled by the ambulance system. We've got a small chart here, of course, that will illustrate this to you.

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Mr. Zimmer: You've got some stats on this.

Mr. Bates: We do. We have stats on almost everything.

This is inter-facility, non-emergency transfers as that now exists. Land ambulance is handling maybe 39% of those calls; 250,000 or 61% are currently being handled by these non-ambulance medical transportation providers. Of course, the question was, should they be regulated? The deputy provided an answer for that, but I'll add to it. In fact, under the Highway Traffic Act, there is a regulation with respect to non-ambulance medical transportation providers, so there's already a regulation and that regulation also allows for municipalities to pass bylaws with respect to these particular operators.

You can see that a lot of the calls you're referring to that were handled by the ambulance have been moved over to this system. There's still work to be done there. We're not saying that all of these calls still need to go by ambulance, because some of them can probably go by other means. What you don't see on there are the 600,000 other calls, transfers that are handled by individuals, families, taxis, paramed services and all these other types of services that provide the necessary movement between institutions. So there's a lot going on in this area.

The Chair: There's about five minutes left on this round.

Mr. Patten: Let me be a little quicker, then. I'm curious about the whole set-up. We've got municipalities, we've got dispatch centres and we've got operators, which may be a city or a hospital or maybe even a private service, right?

Mr. Bates: Shall I answer that? In the sense of right now—

Mr. Patten: The actual operator of the system of sending an ambulance out from a dispatch centre to where the ambulance is and the paramedics and all that sort of thing.

Mr. Bates: The ambulance system is the responsibility of the municipalities, but there are these non-ambulance—

Mr. Patten: What I'm trying to look at is that we have some stats that have been going through for several years where the record is not up to scratch, with 40% of ambulance operators failing to meet certification standards during service reviews, even though they received advance notice of the reviews. That's not a very good system, somehow. So there have got to be a lot of built-in disincentives. There's not an incentive for a municipality to have a high record because it's always whining for more money, essentially. It wants more services, its staff are asking for higher salaries, and it wants better ambulances and the most up-to-date equipment etc. They're never in a position to say, "You know what? We're up to scratch. Everything's fine, great," because the ministry will just say, "You see? Don't come to us with any increased requests or requirements." It's the nature of the relationship, it seems to me. This isn't a criticism of you. I'm just looking at the dynamics of the relationship itself.

We go through these reviews, and the municipality is the operator and the auditor says, "You have to have a system in accordance with certification standards, service reviews, blah, blah, blah. Under what conditions will you decertify or pull the operator's ability to function?" Well, how could you do that if it's a municipality? What are the options there? Do you say, "Okay, we're sending in a trustee," or, "We're going to go to a possible private operator," or, "The province will take over the service"? What are your options if we've moved to the municipality having the chief responsibility for that service?

Mr. Sapsford: It would have to be that the province intervene in some way to manage it. We can't do without the ambulance service, so there needs to be continuous provision. In other regulatory frameworks, that is the model that would be used, so the ministry would move in some way to take over the management until the problems are corrected. It's never a permanent move, but rather a move to gain compliance with whatever the issue is.

Mr. Patten: Have we got the results of the Niagara pilot yet?

Mr. Bates: It's a five-year package. It was only opened about three weeks ago. I had the pleasure of being there. It started in 2004. The official opening was last week. The pilot extends until 2009. It's a five-year assessment period.

Mr. Patten: The auditor was suggesting to move along with that one. On the ones that you're doing in four areas of eastern Ontario—presumably Ottawa is one of them—where this was a pilot in four dispatch centres in eastern Ontario since last spring, the final quality assurance program will be implemented in all centres this month. That means action has taken place as a result of those pilots. Can you elaborate a little bit more on that?

Mr. Bates: There are several points to that, one being the ambulance communication service review, which is similar to the land ambulance review, and that's this particular chart. It utilizes a peer review process and a number of standards that the dispatch centres are measured against. The pilot has just taken place on that particular one and it will be extended beginning this year. We expect to do about three or four more in this year to review a dispatch centre from top to bottom. We described the certification review process last week.

There's also a quality review that I think you're also thinking of there, and that is the quality of the service provided by the actual dispatcher himself or herself. We've got a quality review chart here. It's hard to see, and I apologize for that, but it's useful. These are the particular utilizations. We have a call-taking audit form and a call-dispatching audit form. We have quality control people in almost every dispatch centre at this point in time, and we also have liaison people who liaise with the municipal sector, because they are our partners and we have to work with them. If there's a complaint, they work to resolve that complaint.

This screen, as you can see, talks about these, and they look at everything: Was the call answered within 10 seconds, yes or no? If the question is ambulance, what's your emergency and so on and so forth. They go through all the questions that are necessary to determine exactly whether it's an emergency or what type of call it is. So the dispatchers will be measured and reviewed on that type of screen and call audit system. We hope and we're sure that will also assist in upholding the quality. That's the pilot you're referring to in eastern Ontario.

The Chair: I'm going to go to Mrs. Munro, but before I do that and as part of our turn, I'd like to go back to the numbers. I'll try to get this straight in my mind.

On page 35 of the auditor's report, $241 million was provided to municipalities in the year 2005. Your testimony before, Deputy, said that we were $80 million to $100 million short in terms of being 50-50 with the municipalities. That makes $320 million, the 50% share in 2005. If the municipalities were 50-50, it would be $320 million as well. So the total cost vis-à-vis what the municipality is providing is about $640 million in terms of the service that's provided. Now, of course there's another $120 million or so above that which you're providing for dispatch for 100% funding in unorganized territories and aboriginal communities.

If you take the $640 million then, and you say that in 2008 you're going to be providing about $540 million for your half—if you take $240 million plus $300, which is your estimate—and you multiply that by two because the municipalities are going to have to come up with $540 million, you're up to $1.08 billion. So you're going from $640 million to $1.08 billion in 2005 to 2008, and that's about a 60% increase. You've already had a 94% increase on page 37. When does this end? When does it get any kind of control? Am I right in those numbers?

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Mr. Bates: You're right about the start of the numbers. I think you mentioned before, was it cumulative in the sense of the funding? It is cumulative. You're close on the numbers with respect to the current situation at the 50-50 level. Over the next three years, the movement will be towards achieving the 50-50 level with all municipalities. Of course, there will be some inflation in that particular point in time, but the funding in total is $300 million over the three years to bring the share to 50-50 at the end of the whole period.

The Chair: I understood that it was going to be $300 million in 2008 that was going to be added to your part of the 50% equation. Is that correct?

Mr. Bates: It's a cumulative amount over the three years.

The Chair: In essence, then, it's $80 million this year and a little bit more next year.

Mr. Bates: Yes.

The Chair: That's not what we were told before. We were told before, I believe by Ms. Burton, that it was going to be $300 million, over and above the $240 million in 2005, to make a total provincial contribution of $540 million. Is that correct?

Mr. Bates: She may not have heard the cumulative—it's a cumulative amount. Your analysis is basically right,

in the way you're looking at the current situation moving to a share of 50-50 in 2008.

The Chair: What do you estimate the number for the provincial share of 50% in 2008 will be?

Mr. Bates: It will be about $350 million, something like that. Don't hold me to that number, but it will be in that vicinity, depending upon what the inflation is. I can't tell you what the inflation will be between now and then.

The Chair: Okay. I very much misunderstood the answer. Mrs. Munro?

Mrs. Julia Munro (York North): I'd just like to take a couple minutes to deal with the issue of ambulances spending extended periods of time at hospitals. I notice that this has been one of the areas that you have looked at through the critical care transformation strategy which has now come out. I just have some questions to ask with regard to those recommendations and the monies that have been put forward as a result of that strategy, a number of little questions around this whole initiative. One of the ones I want to know is if you're able to give us a sense of the degree to which that problem of ambulance response time that we talked about earlier would actually be influenced by the kinds of times that are being spent by ambulances at hospitals. I wondered if you had any sense of how much that contributes to the problem of response time.

Mr. Sapsford: We do keep track of the amount of time that ambulances are waiting in emergency, and of course the object over a period of time is to reduce that. The intention of some of these initiatives, the critical care ones, specifically, that you've raised, is really in an effort to begin to have an impact on that. The linkage between ambulances waiting and the flow of patients through the hospital, in my mind, is a direct relationship. Part of the strategy is to partially expand the capacity of critical care units to provide some capacity to hospitals to more quickly admit those patients who require that level of care.

More importantly, the creation of the teams in hospitals that are designed to keep people out of intensive care units is also a critical component. They've been shown in the literature to not only reduce the requirements for intensive care, but also to assist in reducing the length of stay of individual patients. To the degree that hospitals can treat people more quickly, it does ease the pressure on admissions, and hence the impact on the emergency department.

There's no single thing that is going to fix the problem. That's why the emergency department report, Dr. Schwartz's report, dealt with several different strategies, and we're trying as best we can to implement many of them so that we can measure their impact on emergency departments.

Mrs. Munro: I appreciate that it certainly wouldn't be one magic bullet on this one. But my reason for the question was simply that if you think of a community that has three or four or five ambulances—let's say five—and it's possible that two or three of them are sitting at the local hospital, it would seem to me that there would be a link between that and problems around ambulance response time, because you're obviously only dealing with two of the remaining ambulances available if three of them are sitting at the hospital. So I wondered if you had any fix on the degree to which that does impact on ambulance response time, since that's another major concern.

Mr. Sapsford: In quantitative times, no, but notionally I don't disagree with you. I think the bigger impact, though, is because we're trying to keep the response time fixed; in other words, we want to keep improving it. The impact it does have over time is that you have more and more ambulances on the road in order to continue to maintain the response time while accounting for the fact that several of your ambulances are not available for call.

It's a complicated problem, but if we can begin to improve the flow through emergency departments, then would it result in a faster response time? I would argue, yes, it would, to a degree. You would have more ambulance resources to respond, or an overall easing of the total cost because you don't need as many ambulances to maintain the same response time. It's a combination of the two. At this moment, I don't believe we have any analysis that would predict which way that ratio would move.

Mrs. Munro: However, I do think that it's really an important notion because of the fact, as you say, that those ambulances are effectively out of commission. If you're able to identify that over a weekly period there's that kind of drag on the system, then, clearly, that's a huge element of cost, that you've got that group sitting there over the period of time.

Most of the recommendations that come out of this critical care study—I understand why they primarily deal with how to effect a better flow through the emergency department, but I wondered if there were also some recommendations that dealt with the manner in which ambulances do their business. Is there a role there to look at reducing the problem of ambulances sitting at hospitals?

Mr. Sapsford: Yes, that is part of our discussion. I'll give you an example. Let's assume that one has three or four ambulances waiting, with two attendants per patient. I think the current understanding is that the hospital won't accept care until there's a space available. So the way I look at it, to a degree, is that I've got eight ambulance attendants with four patients and four ambulances off the road. There has to be a better way of arranging resources to free up ambulances to go back while still maintaining an acceptable level of care for those patients while they are waiting to be moved through the hospital.

This is part of the discussion that we're engaged in as part of a way to find solutions to this. The municipalities have a part to play in that as well as the hospitals. It's getting that discussion engaged and finding reasonable solutions that will help to make improvements.

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Mrs. Munro: I guess my question my be premature, but I was looking to see if you could give us any kind of description of the kinds of discussions that were taking

place on that side of it, given that we're able to see the results of the discussions on the hospital side.

Mr. Sapsford: St. Michael's is doing some pilot work which you read about. Some of the changes are admission lounges, discharge lounges, where patients for discharge can move from bedrooms so that the beds are available for people in the emergency. So there are strategies around how we can improve the flow of patients on the in-patient side to relieve the pressure. If you relieve that pressure, then you've relieved the ambulance pressure.

Some of them are directed at the hospital issues. There must be a better way to arrange the ambulance staffing when they are waiting. That's another set of issues. Then some of the other questions are about ambulances called in the first place—maybe we have too much volume—and the referral piece to telemedicine and other options, referring lower-level-care-requirement patients, the CTAS 4 and 5 patients, to ambulatory care centres instead of the hospital emergency department.

There is discussion going on at all parts of the system. Some of them are alone, because it's a hospital issue, some of them are joint, because it's the relationship between, and some of them are between ambulance and other parts of the pre-hospital care system.

Mrs. Munro: Would you anticipate that, in a reasonable time, we can expect to see the municipalities and their half of the issue with regard to what we just described, where you have two personnel per patient plus the ambulance—are we going to see some response from the ambulance service and the municipalities on their ideas about how to deal with that?

Mr. Sapsford: That's my hope, yes.

Mrs. Munro: Is this more of a recent problem? I understand it having to do with crowding and issues within the emergency departments, and of course we've heard of those over the last few years, but I just wondered whether or not there had been any kind of change in the legal obligation that has created the kind of situation we see today with ambulance service.

Mr. Sapsford: No, there's been no change in the legal structures. Everyone involved has an obligation to care, and each of them is fulfilling that obligation. It has more to do with a growing and aging population, all of the characteristics you've heard of before. The solutions are being more aggressive around how care is provided and much more aggressive in looking at what kind of process we use around patient care. Are there ways to streamline it? Do we have too many people involved? These are all very complicated discussions, because you have different groups of health professionals who have different views on how care should be provided.

I don't try to make excuses but only to say there is a certain amount of energy required to engage the system in finding solutions to these sorts of problems, rather than just looking at the easy response, which would be, "Provide more money; give us more beds," those kinds of very easy things. This isn't just me saying it. I think the health care system has recognized that it has to tackle these more difficult problems as a system and begin to look for more productive solutions than we've had in the past.

Mrs. Munro: Can you identify in those future discussions the kinds of incentives there would be from the groups to effect any kind of significant changes? You rightly recognize the fact that putting more money into something doesn't necessarily solve a systemic issue, obviously; it feeds it, quite frankly. So I just would ask you to give us any sense of what kinds of incentives you can have in those discussions.

Mr. Sapsford: Unfortunately, I can't today because the whole question of incentives in our funding models is a major issue that the ministry is about to undertake. With the creation of LHINs and some of the changes in the dynamics, one of the things in the ministry that we want to do is begin to re-examine our funding models for health programs. Some argue very strongly there is a series of disincentives, that some of the ways we pay for health services in fact cause behaviours that we wouldn't want to emulate or promote.

Part of the challenge for the ministry over the coming months is to re-examine from a variety of perspectives how the funding models we use create some of the operating problems and barriers that we have today. That's a higher-level review that we'll be undertaking with respect to funding models and incentives and disincentives, and to try to provide incentives, where we can, to promote the outcomes that we want the health system to produce.

Mrs. Munro: Talking about incentives, I know that if someone uses an ambulance to go to the hospital, there is a decision that's made as to whether or not it was an appropriate use of the ambulance and, if it wasn't, it's deemed then as a full-cost recovery. You get this little form in the mail that says, "Please send us $245," or whatever it is. I just wondered whether or not there is any data to support the effectiveness of doing that.

Mr. Bates: You're absolutely right. The system is that on a transport of a patient from, for instance, the scene of an accident to a hospital, the receiving physician makes a decision, assuming the patient has OHIP coverage, of whether it's an essential utilization of the ambulance or non-essential. For essential, there is a $45 copayment fee, and there's the other one you just alluded to for a non-essential call. I don't believe there are any statistics that indicate whether or not it's an effective way of handling ambulance calls. I do know that we get a lot of correspondence about it.

Mr. Bill Mauro (Thunder Bay–Atikokan): I'm sure.

Mr. Bates: But it's basically a methodology that's widely used, if not universally used, across North America. Dollars vary from one jurisdiction to another, obviously; in fact, they vary considerably. They're very high. We spoke last week about the cost of air ambulance. You'll recall that. Land ambulance can cost upwards of $1,000 or more in some jurisdictions if you're not insured or if you're non-essential as well. So there is a great variation.

I don't know of any statistics offhand that indicate whether or not it's an effective way of doing it. You would think it would be a way of making sure that ambulances are used properly, but the thing is that a lot of people only use ambulances once in their lifetime. I don't know who has used an ambulance around here for an emergency call, but I've only ever used it once so far. It tends to be something that you utilize later on or when you're actually in the hospital system. So it's not something that if you're billed for $240, it serves as a lesson that you're going to think about it the next time. I don't think it happens that way.

Mrs. Munro: Actually, that was why I asked, because I don't think people would generally know that this is going to happen, so this would be a surprise to most people. That's why I wondered if you had kept any analyses of it because, if it's a surprise, then obviously it isn't part of the decision-making when that call is made. Equally along with that would be—and I agree with you that people don't make those calls very often. But it would be interesting to also look at it from the perspective of how difficult it is to get the money from these people who weren't expecting to pay for it in the beginning. Again, it sort of speaks to that bigger, broader issue around the kind of incentives, both in a positive and negative way.

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Mr. Bates: If you look at the out-of-province, as we did the last week, I know that personally, it's an incentive for me to get out-of-province insurance before I leave Ontario—if you know about it. But it's the same situation there: A lot of people don't know about it and they don't obtain out-of-province insurance before they leave. It's something that we all have to think about.

I know that the health insurance groups do put out brochures and things like that. You may see one on a doctor's wall or something, but whether or not it's sufficiently advertised, so to speak, is a very valid question that we have to ask ourselves, as is whether anybody would pay any attention to it anyhow when they did see it on the wall because they don't utilize it that often. You're not going to a grocery store, worrying about the cost of milk. It's not something that happens to us regularly, so we don't pay a lot of attention to it, unfortunately.

Mrs. Munro: No, and as I say, in the broader context of the whole issue around incentives and disincentives, that was one where I thought, "Do we have any information on it?"

Mr. Bates: I think you're right in the sense that whenever they developed it, and it's been in place for a long period of time, it probably was thought of as a disincentive.

Mrs. Munro: Right. My final question—

The Chair: You're going to have to wait. The Auditor General had one clarification that he wanted to put forward.

Mr. Jim McCarter: Just on Ms. Kardos Burton's comments related to monitoring municipal spending to make sure that all the ministry funding is spent on land ambulance services, we had a bit of a discussion in the comments earlier on before you came in. My understanding is that the ministry gets a statement from the municipality, basically signed by the treasurer or someone, attesting to the fact that we've spent X amount of dollars on ambulance services. I guess being skeptical auditors, we wondered how you would know if there were a bunch of overheads or possibly even costs that weren't ambulance-related on that statement? So I was happy to see that you're monitoring that now. Does the monitoring include more than just getting the signed statement from the municipality?

Mr. Bates: I guess the monitoring looks at what you think is reasonable. It's a judgment. Obviously, there's a judgment involved in, "Is what they have spent reasonable?" We're going through that now when we're looking at the allocation of funds in a new funding arrangement. Is it reasonable to expect that their costs have been increased by X number of percentage points? You have to look at their wage rates, what they have increased and the benefits. You have to look at the service that they're providing: Did they increase the service that they have been providing, the stations that they have? All of these things are taken into account. So you're right: You have to have a review of it and determine whether or not it's reasonable.

Mr. McCarter: If you found one that just looked like an 18% or 20% increase, you feel you would have the authority to go back and ask for more information or get some more evidence to make sure that it was actually supportable.

Mr. Bates: We've just been doing that very thing. We go back and ask them and confirm with them. Most of them, if not all of them, are very co-operative with us in providing information.

Ms. Kardos Burton: I apologize for having left the room. If I could add to that, just in response, yes, it's more than just the reports. In terms of the ministry, the ministry's role is the standards, and that will make sure that we have a performance standard set for each one of those areas and actually assess what the case is. We have had no issue in terms of getting the municipalities to meet those standards. I think that's a good point and I think it'll actually be even more important now moving toward the 50-50.

Mr. McCarter: That was our concern, obviously. If I'm a municipal treasurer, I know what I might be inclined to do.

Ms. Kardos Burton: Yes. So I think it's incumbent upon us to do that, and we do have some existing methods and will have better ones on the standards, because you have to look at the trends in terms of what's being spent.

The Vice-Chair (Mrs. Julia Munro): Thank you. We'll go to Ms. Martel.

Ms. Martel: I want to continue to work through the response document that you provided to the committee members. The auditor identified a concern in his most recent audit that had come up in May 2004. The auditor referenced a report of the land ambulance acute transfer

task force—and that was a task force between ministry representatives and base hospital representatives—that pointed out that municipalities seemed to be resisting non-emergency transfer requests and ambulance calls that required their vehicles to cross municipal boundaries. One of the impacts of that was that it was having an effect, for example, on the Ontario stroke strategy. So I wondered what this particular item that was noted by the auditor in reference to a previous report—is this part of the discussion that's going on with the land ambulance committee, and what's the nature of that discussion?

Mr. Bates: I can have a stab at that, if you will.

Ms. Martel: Okay, Malcolm, but not too many slides; okay?

Mr. Bates: No, we've only got three this time, if you don't mind.

Ms. Kardos Burton: If I can, while Malcolm's doing that on the stroke strategy, I think one thing that's important is that we're talking about one municipality in terms of not being as co-operative as they could have been in the stroke strategy.

Ms. Martel: I understand that, but I gathered it was a bigger problem in terms of municipalities generally not wanting to have their vehicles cross municipal boundaries, and part of what they were doing was perhaps centralizing in a more downtown location versus at the edges of their boundaries in order to actually avoid that; so a more strategic placement of ambulances. I don't know how true that is. I'm referencing a report that the auditor referenced. So I want to know, is that on the table from the ministry's perspective? Is this part of the discussion that's going on? I'm not sure it's been raised by the municipalities. If it hasn't, is it being raised by the ministry?

Ms. Kardos Burton: Certainly from a principle point of view, the cross-border billing issue shouldn't get in the way of how you deliver services to the citizens of Ontario.

Ms. Martel: There's the billing issue; I understand that. But there's a second issue, to my mind. Maybe I'm wrong about that. The issue out there has to do with billing and data and are you going to have billing for the transfers. The second thing is, do you have some municipalities that are more strategically locating their ambulances in order to reduce what might be their exposure in this regard?

Mr. Bates: If I may answer that one, municipalities are, as we just talked about a little earlier, concerned about emergency response times. So it's natural for them—and I would hope that they do this—to look at the location of their ambulance stations. Many of them have done this. Some of them have employed outside consultants.

I've got a report, if you wanted to have a look at one, as to whether or not the stations where they are currently located are adequate or if they have to change those particular locations of stations. Naturally, those locations would move toward where the population is, where the demand is. That's what they're looking at. It doesn't necessarily mean, when we had the stations before, they were aligned with demand. There was a lot of historical perspective attached to the ambulance system prior to the municipalities taking over. I know you understand that in the area of Sudbury, but the fact of the matter is, municipalities are very concerned about station locations. I can tell you this: We had something like 330 stations; now there are over 400-and-something stations in the system. So 69 extra stations have been added in the five years since the municipalities have taken over. That's a significant change.

Most of those stations are adjusted to where the demand is. So it's a logical move on their part to do that. Now, are they concerned about out-of-jurisdiction, if you will, calls? Absolutely they are. That's part of a municipal system. The same thing exists with respect to fire departments. I'm sure you can understand that, that they want to service the citizens they have. The Ambulance Act and all our policies call for the closest ambulance to be sent, and they all adhere to that when it comes to emergencies.

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Non-emergency calls: There's a little greater flexibility in the timing attached to them. In fact, they work with us, but there's no question they prefer and are working with the hospital system, similar to the LHINs, as the deputy was saying before, to try and find out different ways of moving patients who don't require ambulances. We spoke about that before as well, and they've been very successful in working with the hospital system to make sure that the hospitals are utilizing the proper type of transportation necessary.

The stroke strategy was something that was mentioned by the Auditor General. The stroke strategy is an initiative of the ministry and the Ontario heart foundation. It's across the province, a system with respect to a stroke strategy. We've got the ones that are currently functioning with respect to acute stroke protocols in the province.

You can see that the stroke protocols in the province in the blue have been implemented. The ones that are under development are green. Northern Ontario, I'm sorry, is down here, but you can see that, if you will. There are some notable exceptions. One is here, sort of thing. The concern that had the auditor's time when they were looking at it—there were two municipalities that were concerned about a functioning stroke strategy. The stroke strategy is that there are nine regional stroke centres. They have to be 24 hours a day with coverage and they have to have CT scans and neurologists available. There are, I think, 18 district stroke centres as well across the province. These particular communities have reached agreements with the hospital system that they will transport patients to a stroke centre, wherever it may be. And you can see Niagara as well has now agreed to that. There is no problem with respect to transporting stroke patients in that particular area at this point in time. But the concern they had was not so much transporting across boundaries but the cost of it. That was their main

concern, the two that mentioned it to us and the two that the auditors were able to mention in their particular report. I would say that that now should have been resolved, or will be resolved with the announced funding of a 50-50 share.

Ms. Martel: I appreciate all that. Let me go to page 39 of the auditor's report, where the auditor, midway down, says, according to the May 2004 report—and ministry reps sat on this, along with reps from base hospitals—"'municipalities are resisting non-emergency inter-facility transfer requests, and ambulance calls that require their vehicles to cross municipal boundaries'"—resisting that. What I want to be clear on is, you have a land ambulance committee that is meeting now. Is this part of the discussion—

Mr. Sapsford: Yes.

Ms. Martel: —either brought forward by the municipalities or brought forward by the ministry?

Mr. Sapsford: Yes. Resisting has not yet, to my knowledge, meant refusal, and resisting is directly proportional to this issue around funding, I think it's fair to say. So the hope is that if we come to a successful conclusion around the funding issues, the resistance about moving non-urgent across boundaries will evaporate in that agreement.

I think the auditor pointed out a symptom, but I guess our assessment is that the solution to that is found in coming to agreement around the funding relationships.

Ms. Martel: All right. We can anticipate we will see some kind of a response to that issue when the committee responds in a more public fashion with recommendations.

Mr. Sapsford: Yes.

Ms. Martel: Okay. Let me deal with the next issue of defibrillators, which you referenced in your report this morning. You said that there's a committee that is assessing this particular situation. It was due to report back by mid-December. I wondered where the recommendations were on this matter at this point.

My other concern had to do with the fact that we've had some recommendations already in the past from some other groups about at least putting defibrillators in casinos, for example. That goes back to a 2003 OPALS research work. In 2004 OPALS also suggested that perhaps placement of defibrillators in shopping malls would be beneficial.

It looks like neither of those things was followed up on and we're studying this some more. I wondered why we hadn't at least taken those two steps, since I think that OPALS research is pretty credible. That would be my argument. I wonder if the problem is who pays for this. Is this a ministry share, or is this a municipal cost, and is this part of the dilemma?

Mr. Sapsford: On the whole issue of the defibrillators, because, as you say, recommendations were coming through from a number of different sources, some of them based on solid thinking and, quite honestly, some of them not, we asked the technology assessment committee to do a full-scale review, and that report is the one you've referenced. Where is it? It's actually in front of me at the moment.

Ms. Martel: Do you want to tell us some more about it?

Mr. Sapsford: Well, I have brought staff if you'd like to hear more detail about it, but we tried to do some serious evaluation of the effectiveness of it against the costs of it, to try to establish what would be a reasonable thing to do. I think a couple of the issues are important for consideration, which I will have to consider. One is training: These things don't work properly, or they're not effective, without the appropriate training. As soon as you say the word "training," then someone has to be responsible. Even with the thought of putting one in a shopping centre, the question remains, who's going to use it if you need it—against the frequency of an occurrence in a shopping centre, and how much does it cost to maintain it? That's the nature of the work that's been done in quite an objective and analytical way. It does point to it being reasonable to consider putting them in certain locations and quite unreasonable to be putting them in what I'll call more general public places.

That's the nature of the report that has been given to the ministry, and now we have to look at it. I should add that the dollars are substantial, and there still is the question about how many lives you will actually save in any period of time for the amount of money that needs to be expended.

That's the general overview for the committee. Dr. Les Levin is here, and one of his staff who actually did the research, and if you'd like to hear more specific information, we'd be happy to provide it, Chair, if you wish.

Ms. Martel: I'm not clear who pays. Does the organization where it is located then essentially become responsible both for training and for payment of the equipment?

Mr. Sapsford: That's one of the questions: Is it something that the Ministry of Health would pay for, and who has the liability? There are some legal questions that need to be sorted out as well. I don't believe the report looked at those aspects of it. It was more just the efficacy of use of the defibrillators and what the statistics say about the outcome of use and the frequency of the occurrence of heart attack in those situations.

Ms. Kardos Burton: If I may, in looking at the report, the review looked at whether it should be in public buildings, whether it should be in airplanes, but the expectation would be that those organizations would pay for them.

Ms. Martel: What's the cost you're looking at? I don't have an understanding of that.

Ms. Kardos Burton: A lot.

Mr. Sapsford: Again, it varies, depending how widely spaced. The study was done, it was stratified by types of locations, so you look at hospitals, all police services, fire services, then look more broadly into things like long-term-care homes, other types of institutions, and then into residential homes or multiple apartment

buildings. The analysis was stratified across the different types of locations, and of course, the costs go up proportionally from there. The mid-point would be tens of millions.

Ms. Martel: All right. Let me move on. Thank you for that information.

I wanted to follow up on a question that Mr. Patten was asking about the review of the ambulance operators. I had a couple of questions in this regard. I see that the Provincial Auditor had recommended unannounced service reviews, and the ministry had responded that their feeling was this would be very disruptive, which is a fair enough analysis. My concern, though, was this: Right now, as I understand it, ambulance services are told that there's going to be a review. They could get up to 90 days of pre-advance notice, and yet, even with a pre-advance notice—let's take the outside of 90 days, which is three months—you had 50% of operators who did not meet their certification standards in 2003-04. As I look at it, that's a really high number of operations that don't seem to be in compliance, even with three months' warning. I can't imagine what it would be like if there was no warning. Is this of concern to the ministry? I appreciate you don't want to move to a system of not warning, but goodness, if after three months you still have 50% that don't comply, what's the nature of the problem here?

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Mr. Bates: We're very rigid, if you will, because we want very high standards. In the review, there are something like 1,200 questions that are asked with respect to the operator. There are over 200 standards that we utilize to look at each one. We ask for a 90% result before we certify an ambulance operator. They may not reach 90%. They may have something less than 90%, and a lot of that, quite frankly, could be administrative matters that don't impact directly upon the health and safety of patients or of the paramedics themselves. We're a little less rigid about those—and we want to go back in.

We send them a report and we say, "Here are the things that you must adhere to," and we outline whether they're regulations and legislative concerns or whether they're policy concerns and things like that. They have time to upgrade themselves. There's no doubt about it. We go in with a follow-up team to review whether or not they've actually met them.

Now, there are circumstances in which we are concerned about the health and safety of patients because we found that in fact those reviews showed that the operator was not performing well, was not doing a good job and there were real difficulties associated with that particular service. We then issue director's orders. Even though we're partners with the municipal sector—and some of the municipalities use contracted operators, to be frank. They're not all operated by municipalities, but a good number of them are, if not the majority of them. We issue director's orders associated with that and they have about 20 days to respond and ensure that things are done properly.

For instance, here are a couple of orders just to give a flavour of the types of things that we do. In one order that we sent out in 2004, we said, "You must do something about this, because we found the patient care compartments in a number of ambulance vehicles to be unsanitary and unclean. We found the base locations unclean and untidy. Patient supplies found to be unclean, unsanitary and defective." You've got to do something about that because obviously those are things that directly impact upon patient care.

Another one was failure to provide incident reports, despite notices and reminders. This is one thing that the auditor also mentions, so we are following up on that.

Personnel records are very important, because there are situations in which we have found—and I think you'll appreciate the same sort of thing occurred with respect to nurses—the paramedics, for instance, are not qualified to function. For one reason or another, they have been hired and their credentials are not correct. They are not adequately qualified. When that happens, we go right after it. We make sure that that is changed, that something has to take place with respect to that. So personnel records are very important. They have to make sure that the people they hire are indeed qualified.

There are a number of things that we in fact follow up on and we issued director's orders, and then it's a direct follow-up thereafter. Now, each one of them where we've done this has indeed followed up and have performed thereafter. They've cleaned up their acts and things are in order in those particular locations at this particular point in time, but it's something that you have to constantly follow up on, constantly be aware of.

The auditor was concerned, quite rightly, about unannounced visits. We do about 100 and some odd unannounced visits each year. That may range from a total inspection, which we have done—when we went into that particular location, we found, again, unclean ambulances—to simply a visit by an inspector to go in and have a coffee, have a look at the ambulances, talk to the staff and do that sort of thing, but at the same time looking at what's happening to determine whether or not this system is working the way it should.

Ms. Martel: Let me deal with the follow-up, because the auditor pointed out that those follow-up visits are scheduled for 60 to 90 days following receipt of the operator's response. I thought that was excessive actually, especially given that there could be up to a 90-day notification to the operator that the ministry was coming. You're talking from the time that this all starts to the time that there might be a follow-up, which could be between six to seven months. Is that a function of the ministry in terms of staffing, the ability to actually get back in there? I just thought that was excessive.

Mr. Bates: You're right in some ways, in the sense of—first of all, let's say that we're in a new sort of transitional type of work. This is only five years old, since we've moved over from the local services realignment. Not only do we have to look at different ways of doing things and staff up—our situation is no different

from the Auditor General, when he mentioned in his overview that he had the challenge of an expanded mandate, and you can notice that in his report. We have the same thing, so we're staffing up; we're working along the same lines as the Provincial Auditor has to, in the sense that we have to get the right type of people in to do the certification. We have to make sure that they're qualified, that they're trained.

Municipalities also—a five-year-old municipal service, and most of them are less than that because they've just moved over from private operators at hospitals to direct service. In all fairness, they have to have time to adjust as well, not only to the new system we're operating but to the type of rigid quality we're looking for. It's something that does take time. In the multifaceted system we have, the certification review is just one part, as I said. We have unannounced visits and investigations. Our dispatch centres are tasked with overseeing what happens in the municipalities all the time.

Of course, we're looking at the paramedics. There were nine orders issued for paramedics in the last year with respect to their qualifications. When we found they weren't doing the job, we went in and made sure things were changed. All of those nine had to rewrite their examinations in the last year.

The Vice-Chair: We have to move on. I have Mrs. Sandals first.

Mrs. Liz Sandals (Guelph–Wellington): I wonder if we could go back to the slide you showed initially around response times, not the newspaper headlines one but the one that had the actual response times for the different areas. This sort of hit a hot button as we were looking at those slides, because it seems to me that what was embedded in the 1996 response time standards—I'm having trouble seeing these—if I look at response times, they're all over the place. While you would expect to see that Parry Sound and Muskoka would have similar ones, and they've got 27 and 24, if I look at southwestern Ontario, we've got response times varying from 10 minutes in Waterloo, which, granted, is more urban; Brant, which is not more urban, 12 minutes; Niagara—large parts of that are rural—10 minutes; ranging up to, Wellington and Perth are more 16, 17, 14; Dufferin, 16; Simcoe, 15. One is 50% higher than the other.

If you go back to that other one you saw, which is the definition of what a "response time" is, it would seem to me to be all over the place in terms of the definition. In some places, it's when does the ambulance—yes, that one; no, the one that actually shows the definition of "response time." It seemed to me that in that definition of "response time," for some places we're talking about from the time the line rings to the time an ambulance shows up. At other times, it's when somebody was rolling, and it may be when the first responder shows up, which to me means when the fire department shows up, in a lot of cases.

It seems to me that these things are all over the place for similar geography and all over the place in terms of definition. I'm wondering why we're using that as our measure of whether or not people are meeting the standard, because it seems to me, quite frankly, to be a meaningless standard.

Mr. Bates: This chart illustrates what happens across North America.

Mrs. Sandals: Oh, okay.

Mr. Bates: I didn't get a chance to get to that particular one.

Mrs. Sandals: So why do you say "Ontario definition"?

Ms. Martel: I cut him off.

Mr. Bates: That's right.

Mrs. Sandals: What's the Ontario definition, then? Do we have a standard Ontario definition?

Mr. Bates: I was going to get to that.

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Mrs. Sandals: Okay. But having said that, I know that locally, in my own area, for example, every crew has—I'm not sure of the right name for this, but there's one level of paramedic and then there's an advanced level of paramedic. In Guelph and Wellington, every ambulance crew has one person trained to the higher level. I think that is not the case in many areas of the province.

Again, it seems to me we've got all sorts of things going on here, but I guess the bottom-line question is, and you might want to comment briefly on that, am I right or am I wrong? Assuming I'm right that things we have set up as standards are really apples and oranges, are we doing anything about trying to create apples?

Mr. Bates: We certainly are. It takes time, and I'm sorry it takes time, but this is from the journal of emergency medicine with respect to EMS providers in the United States, and us too, because we participate.

Mrs. Sandals: Okay, but what's the standard in Ontario?

Mr. Bates: The standard in Ontario: When the ambulance is dispatched, it starts the clock. We also have a chronology. That will help better. This is the chronology of an ambulance call. It takes into account a number of the things we talked about earlier today as well. For instance, 911, and 911 is universal across the province: 911 takes the initial call and decides whether it's fire, police or ambulance. We don't run 911. That's usually a municipal system or a police system across the province. The 911 operator puts the call in to our dispatcher. Our ACO, ambulance communications operator, says, "Ambulance, what's your emergency?"

Mrs. Sandals: So when do we start our measurement in that standard?

Mr. Bates: We've got two different standards, okay? One from a dispatcher and the call-taker within the dispatch centre itself. They have this dispatch reaction time standard and I think that was mentioned by the Auditor General as well. This is a dispatch reaction time. It's two minutes, as a standard that we have, to take the call, to make sure it's an ambulance call and decide what the emergency is, what needs to be done, to pass it on to a dispatcher who then dispatches the appropriate ambulance.

We utilize, as far as our response time measurement for—because it's a municipal system. We're measuring the municipalities at this point in time. We measure from this time, at which time the ambulance dispatcher notifies the paramedic of the priority and pickup location of the patient. The ambulance response time—

Mrs. Sandals: So that's the point at which dispatch sends out the ambulance.

Mr. Bates: That's right. That's the start of a response time. It entails all of these particular times. From the time it departs the station and the paramedics are en route until it arrives at the scene and advises the dispatcher centre, "We have arrived at the scene of the patient." That's the response time there.

Then you have, going on—you were asking about what type of paramedics. I'll be able to provide you with that information in a second. The paramedic provides the patient care here, from the scene of the accident, the heart attack or whatever, makes sure the patient is stabilized, whatever care is necessary, and transports to the hospital. This is, as we were talking about, the hospital time, this particular time, until they're finished and return to base.

Those are the overall aspects of an ambulance call. Dispatch reaction time is something we measure and look at. Ambulance response time is something we look at and measure. As the deputy mentioned—

Mrs. Sandals: So the ambulance response time, then, is what is on that chart we were just looking at.

Mr. Bates: Yes, the map.

Mrs. Sandals: On the map, okay, and they are for similar geography and would appear to be all over the place.

Mr. Bates: Yes.

Mrs. Sandals: Are we doing anything to come up with what the standard should be, or is that an insoluble problem?

Mr. Bates: No.

Mrs. Sandals: So we are comparing apples and apples rather than just yearly variations.

Mr. Bates: The land ambulance committee, as the ADM mentioned earlier, is looking at response time and response time standards. We will be actively reviewing their recommendations with respect to response time, and how it's measured and how it should be measured.

Ms. Kardos Burton: If I may just add to that, because there has been a fair bit of comment obviously in terms of what Ontario's standard is, 90% of what it was in 1996, has variance throughout the province. So you're absolutely correct. As Malcolm mentioned, in the committee, we are looking at that, and this is with municipal representatives as well as us. The important part that I just want to add: It's with the principle of making sure that you've taken into account the reasonableness in each local area. I think that's what's been missing before. What it was 10 years ago may or may not have been valid. It's something that's understood and recognized, and hopefully we'll have a response time standard that is more palatable and understandable to citizens in Ontario.

Mrs. Sandals: Okay, because it seems to me that the crucial piece is what's reasonable given the geography.

Mr. Bates: That's right. This may help because—

Mrs. Sandals: I know my colleagues want to share.

Mr. Bates: Okay. I'm sorry.

Mr. Mauro: Mr. Sapsford, it seems that there's a connection being attempted to be created between higher costs and at the same time reduced service delivery, at least in terms of response times. It's my understanding that most of these increased costs are simply wage-related issues. I'm looking for a response on that first, simply a yes or no. I think that's accurate. Is that fair to say?

Mr. Sapsford: The bulk of their budgets are staff-related, yes.

Mr. Mauro: It's 85% or so. So when we look at higher costs and try to say, "What are we doing? We're inefficient," it's not so much inefficient; it's just simply that wages have skyrocketed. It's my belief that wages skyrocketed when we went to this new delivery model. What we saw was a competition created across the province for the services of these highly trained people. As a result of that, a competitive bidding process and the arbitration process got involved, and then municipalities like the one that I come from were suddenly faced with trying to match arbitration awards or negotiated benefit awards that were being meted out in communities like Mississauga and Toronto. Would you agree with that?

Mr. Sapsford: It's a factor.

Mr. Mauro: It's a factor. Thank you very much.

Mr. Sapsford: But just to say that part of increasing costs are also more ambulances on the road. It's a combination.

Mr. Mauro: Fair enough.

The $300 million to be cleared is the amount of money that's estimated to be needed in 2008 based on estimated 2008 costs to fully arrive at a 50-50 funding formula. Have I got that captured?

Mr. Sapsford: Yes.

Mr. Mauro: The money in this response times issue and the response times seeming to go down: Would you say that this is less about trying to place blame on the previous government than it is trying to determine exactly what's happened here? If we were to look at data on response times and the 1996 benchmark is no longer being achieved, and if I wanted to try to determine what caused that and when it happened, if we were to look at the timeline from the beginning of this process in 1998 to fully implemented in 2001 by the municipalities, would it be likely—or you may know—that the response times immediately began to decline when the new operational delivery model was implemented? It being a function of that is what I'm trying to determine, so that when we devolve this responsibility to municipalities and DDAs, it was the operational model that created the slower response times as municipalities were trying to wrap their heads around how they were going to do this.

Mr. Sapsford: I don't have any quantitative information to back it up, but I think notionally—

Mr. Mauro: If I went year by year, if I went from 2001, when this started, we might see response times go like this; if I went to 2002, we might see it. But it would

be my expectation that we would begin to see that level off once the operational model has been fully implemented. It would make my point that this is a function of how we're delivering the service now, not what's going on in terms of how we're trying to do it from—do you get my point?

Mr. Sapsford: Absolutely, I do. To me, the way I would say that is that it's a function of the change. New people are taking on operation. As you heard Mr. Bates say, the ministry changed its role. It was divesting services, picking up the new monitoring role—

Mr. Mauro: So the decline in response times would have probably happened precipitously at the beginning of the new operational model and then likely levelled off and remained static since that process has been in place. Is that fair to say? Likely?

Mr. Sapsford: I understand what you're saying. I'd have to go back and look at numbers to approve the case.

Mr. Mauro: Okay, so it's a function of the operational model.

The $96 million: It was in one of the pieces of information we had to address the off-load times at the hospitals: Can you talk to me a little bit more about that?

1150

Mr. Sapsford: That was the critical care package. So it's a combination of initiatives, some of it related to critical care bed capacity, some of it to create new clinical teams inside hospitals that will respond to patients who are developing symptoms that might argue for critical care, and to take the expertise to the bedside outside of the unit. So these two together are the bulk of the response.

Mr. Mauro: When an ambulance shows up at a hospital with a patient and they can't get the patient offloaded because the emergency room is backed up, would that possibly be a function of more people going to emergency rooms because there aren't enough family doctors in the province for a variety of reasons and more people are using emergency care now, and also a reflection perhaps of the fact that there are far fewer acute care beds existing in the hospital sector than there were 10 or 15 years ago?

Mr. Sapsford: I would agree with both of those.

Mr. Mauro: Thank you very much, Madam Chair. I have to leave, but if we have some more time, I'd be happy to kick it back to my—

The Vice-Chair: Mr. Zimmer is next.

Mr. Zimmer: Just a wrap-up question before I tear out of here: On balance, looking back on the pre-transfer days and today, would you say that in terms of the patient/user, in terms of the financial management of the service and in terms of the administration of the ambulance service we're better off today than we were pre-transfer? In what areas are we better off? In what areas are we in a worse situation? I recognize that's a political decision.

Mr. Sapsford: That's a judgment I'd have to think long and hard about, I suppose, as to where we are versus where we were. I think the clarity in roles of who is doing what and who is responsible for what is much better. It stakes out clearly the role of municipalities and who our land ambulance operators are, whereas before, we had some municipalities, some private, some hospitals, and the ministry ran some. So there was a broader patchwork of services, and the ministry also, with the regulatory role, in the middle of it.

So from just the clarity around who's responsible for what, I think we're in a better position. I think the ministry, in terms of the regulatory framework and its compliance management process that the auditor has commented on—it's a better model for the province to use in improving standards and performance over time.

Inevitably in any kind of change, there are going to be discontinuities and dislocations, and I think the report indicates some of those areas, but I think over a period of time, we'll have a much more consolidated and a clearer approach to service delivery.

Ms. Kardos Burton: If I could, I'll add my comments in terms of some observations. First of all, you'd have to do some sort of true evaluation to really know, but I think the opportunities in terms of integration with fire and police and first-response are a good thing. I think, from what I've seen—and it's not overall—in terms of responsiveness and education to the citizens in communities, there have been more efforts paid locally and money paid in terms of making sure that there are education processes.

I also think that one of the things it has done in transferring land ambulance services to municipalities is challenge governments in terms of how things are done, because there is a variety of different approaches, and I think there have been some innovations as a result of the transfer as well. So I'll make those comments just from my observations over the last few years on the land ambulance file.

Mr. Bates: This may help, statistically. I mentioned before about the number of ambulance stations increasing. There's been a 21% increase in the number of stations since the transition has taken place, an 18% increase in the number of ambulances on the road, 50% in terms of the number of emergency response vehicles. Those are simply vehicles that are operating. You'll see them around Toronto, the one particular paramedic in a Suburban, for instance, responding to the scene of the accident. There's a 50% increase in those, 50% in terms of its support vehicles.

I think Mrs. Sandals mentioned the number of paramedics on the road. There's an 11% increase in the number of paramedics, a 138% increase in the number of advance-care paramedics since the transition, and a small number of EMAs, local volunteers and so on; they have decreased. Statistically, it has changed to the positive.

Mr. Zimmer: Just one last question to the deputy: If you were to rank or list your three biggest challenges on this issue, in order—one, two, three—what are they?

Mr. Sapsford: For the ministry?

Mr. Zimmer: Yes. The three challenges and in what order,

Mr. Sapsford: Resolving the outstanding issues related to the shift in business operation, and that speaks to issues around the funding and the cross-border questions that are on the table; ensuring that the ministry's compliance functions are up and operational and that we've got reasonable and acceptable standards against which we're doing that work; and I guess the third one would be making sure that the technological advances in information systems to give us the tools to actually do this are adequate and in operation, and that speaks to some of the pilot projects that we're operating.

Mr. Zimmer: Thank you for that third one. That's one of my pet interests here. Thank you, Mr. Chair.

The Chair: Mr. Milloy has not had an opportunity to ask any questions so far, so I'm going to give him about two or three minutes.

Mr. John Milloy (Kitchener Centre): Thank you. I'll be brief. I have a list of questions, but I just want to pick up on one aspect of your presentation on ambulatory care centres. You talked about one of the strategies you were looking at as having ambulances take patients with less severe problems to these centres. I guess it's a two-part question: One, I've seen bits and pieces in the media about the formal establishment of some of these centres. I think some of them are in hospitals and all that. This is a little bit off-topic, and I'll bring it back on topic, but can you just give me 30 seconds on what the strategy is in terms of the area and how you're going to be going about implementing this strategy? I think it's going to have a huge impact on some of our emergency rooms, which all of us around this table hear about all the time.

Second, how will that impact the ambulances? For an emergency situation, are we starting to enter into new territory where the ambulance driver or the paramedic has to decide sort of which route to go to? Do you anticipate sort of a culture change in terms of dealing with those issues?

Mr. Sapsford: Yes, all of the above.

Mr. Milloy: Thank you—no.

Mr. Sapsford: Well, it's an innovation and, in order to achieve that, those are the kinds of questions that are on the table. How do we make those decisions? Who makes them? If it's the paramedic, is there adequate training and/or supervision? What is the range of clinical conditions that would fall into that consideration? What are the absolute will-not-dos? That's the nature of the discussion to make it work.

A lot of this can be predefined and identified clinically, so that it's really only the grey areas between classifications where I think the discussion occurs. It's aimed at those patients who, in our vernacular, fall into the CTAS 4 and 5 classifications, which are people who generally walk in, have low-level complaints and sometimes ambulances are called. It's trying to separate out that patient load and redirect it to ambulatory care centres.

It doesn't deal with the problem of patients going into the hospital as in-patients, but it does free up just the general pressure on the emergency room and to the degree patients are there occupying clinic rooms and so forth. It allows the hospital to use that space and resource for people who do require more immediate attention in the emergency room and then would allow the ambulances to move back onto the road more quickly.

Mr. Milloy: Can you just outline what the strategy is—I know this is a little bit separate but I'm just curious where we're going in terms of these centres. I've seen some talk in the media. Two have been established in Toronto and I think one somewhere in southwestern Ontario. Is there a criterion by which you're establishing them?

Mr. Sapsford: Yes, there is an ambulatory care centre policy framework. There aren't very many of them in the province. There's one that's been in Stoney Creek for many years. It's a well-established and well-developed one. They're always owned and operated by hospitals, so they're seen as adjuncts to a hospital's services. They generally provide clinic care. Some of them are now moving into providing surgical services on a day basis. The centre in Stoney Creek provides day surgical services.

They're being looked at more and more as providing adjunct service to hospitals and being the link between acute in-patient care and the primary care system.

Mr. Milloy: I have a final question. We don't have one in my area, for example. I guess I'm just asking, what's the long-term strategy? Are hospitals going to be encouraged to set them up? Can a hospital apply to set one up?

Mr. Sapsford: We're looking at them as being an innovation, yes, because they take what were defined as hospital services and bring them closer to the community in different locations, in many cases. It's not all new service, though. It's a trade-off between what the hospital is doing in its main facility versus what it would do in the ambulatory care centre.

I won't say we're marketing the concept. It's really in the hands of a hospital to determine how it wants to organize its services. But it's becoming more and more an option that hospitals are looking at.

One issue that came up as a result—

The Chair: I'm going to have to interrupt. I'm sorry, Deputy. There's a bell ringing. There's about three and a half minutes. Perhaps you could complete your response when members return from the Legislature in about 10 minutes.

Mr. Sapsford: That's fine.

The Chair: We'll have a 10-minute recess.

Mr. Zimmer: Are we going to break for lunch?

The Chair: What I suggest members do is pick up a sandwich on the way back in. I think Ms. Martel and Mrs. Munro still had some questions. We will be finished by, I'm guessing, 12:30 or quarter to 1; maybe 1 o'clock.

So we'll see you in a few minutes, those who want to go and vote.

The committee recessed from 1204 to 1215.

The Chair: Let's go. Did you want to add anything to your response to Mr. Milloy?

Mr. Sapsford: Just to the last thought I had about the ambulatory care centres. One of the lines of thought around ambulatory care really came after the SARS cases several years ago when hospitals realized that in the face of those kinds of infection control problems, much of the hospital's operation had to cease, and because a growing proportion of the hospital's operation is related to outpatient and ambulatory care, people started to quickly conclude that we really need to begin to think about physical separation of some of our services in the face of these kinds of outbreaks. Because the ambulatory care model's clinics, day surgery and so forth don't of necessity have to be in the same building, it's led to more thought and discussion about these free-standing ambulatory care centres. So I think it's an issue of growing interest that we'll see more of in the future as hospitals rethink how they provide services.

The Chair: Ms. Martel.

Ms. Martel: I wanted to ask for two bits of information, and you don't have to give them to me now. You can provide them to the committee, Deputy, if you don't mind. The first would be with respect to the dispatch centre response times, which was item 4 on our chart. We had information from the auditor with respect to 2004 that 15 of the 18 dispatch centres had response times that were more than what they should be, the two minutes. I know you said in your report that you're monitoring that monthly now. I would like to know if you could give us some information about what the response times are now for the dispatch centres since you've been doing the monthly monitoring. How many are now meeting the two-minute standard out of the 18? For those that are not, what kind of corrective or remedial action is the ministry trying to take to get them within that two-minute response?

Mr. Bates: We have your answers here.

Ms. Martel: These are for 2005?

Mr. Bates: Yes. The green are the calls dispatched within two minutes of call receipt, and this is each of the dispatch centres down here and the percentages. For instance, in Thunder Bay, they're meeting it 97% of the time. There are places that are not doing as well, obviously, when you see the green go down: 84% for London; Lindsay is 70%; Kingston is 84%; Hamilton is 84%; I'm sure you'll be interested in Sudbury, which is 89%. So there is a variation; there's no question about it. It's a five-year plan that we have to—

Ms. Martel: Even if you look at that 89%, 89% of the time they're doing it within the two minutes, which is okay.

Mr. Bates: That's the standard.

Ms. Martel: So when the auditor said 15 of 18 were not, he was very conclusive that those 15 were not meeting the standard 100% of the time.

Mr. McCarter: Yes, and the stats we had were 2004 stats.

Ms. Martel: Can we get that as 2005 statistics, since we've some more recent information? Jim, if your office can get it in the same format that we already have in the report, that would be helpful.

The second area was the land ambulance operators. We had statistics, between 2002 and 2004, for how many operators were not meeting certification standards. I'm hoping that you have some more up-to-date information for 2005, and I wonder if we can get some information from the ministry about how many didn't meet the certification standards in 2005. I don't need to have that right now, but if you want to give that to us, that would be great.

Mr. Sapsford: We'll provide that information to the committee.

Ms. Martel: The last point I want to raise—I've left it till the end, but it is probably one of the most important ones that I want to get on the public record. Frankly, Deputy, it's to ask for your assistance into looking into a matter that has gone unresolved for a very long time. I raise it on behalf of our Manitoulin-Sudbury District Social Services Administration Board, but frankly on behalf of the other northern ones, because they are all essentially in the same situation.

You said at the beginning of your remarks, and it is true, that the province picks up 100% of the approved costs for emergency services in those territories without municipal organization, and there are many across northern Ontario. The dilemma that DSSABs continue to have is that unlike other ministries on whose behalf the DSSABs provide services, the repayment or payment of those emergency services is one year behind.

Let me give you an example. Right now, a district social services admin board sets its budget. They apportion the relevant cost to the municipalities that are in their jurisdiction. For those areas that are municipalities without municipal organization, each of the ministries is told what the costs are going to be for that particular year. That would include social housing through MMAH or Ontario Works, ODSP through MCSS, child care etc. It seems that the Ministry of Health is the only ministry that pays 100% of these costs, like the other ministries, but do it a year after the fact. The DSSABs are always one year behind in terms of having the actual costs of emergency services, that portion related to municipalities without organization, being picked up by the ministry. Every other ministry flows the amount of money that they owe on an ongoing and regular basis in the fiscal year where the costs are being incurred. The Ministry of Health, for a reason that I do not understand and nobody seems to understand, is always a year behind, which means that the DSSABs are always trying to pick that up and are always behind financially with respect to only the Ministry of Health.

1220

I would ask for your commitment now for folks to have a look at this. I don't think it's part of the discussions at the land ambulance committee. I suspect you've got organized municipalities and they've got a different focus. This is a very serious concern that's probably not being raised at any table at this time or, if it

is, it's not with much haste. I'd be happy to share more information with you, I'd be happy to put you in touch with whoever you need to be put in touch with, but this is an issue that really has to be resolved. It has serious financial implications, not just for our DSSAB but for the other northern ones, and it has gone unresolved for far too long.

Mr. Sapsford: I'm not familiar with the details of that, but I'll certainly ask and report back on the issue.

The Chair: Do you have any more questions, Ms. Munro?

Mrs. Munro: I just have one, and it goes back to the issues I was raising earlier with regard to the problem of the ambulance being at the hospital. I know that in a lot of the work you do, you are looking at other jurisdictions, and we know they also have problems with emergency room service. I wondered if they have a similar problem with ambulances and if there are any best practices you've looked at in these other jurisdictions on this issue.

Mr. Bates: I can have a go at that. You'll recall the previous auditor's report back in 2000, where they were concerned about the redirection of ambulances. Subsequent to that report, there was a lot of work performed by the hospital community and the ambulance community to come up with a different system of sending patients between facilities. A patient priority system, they call it, and it was put into place and implemented. It has worked very well. It allows the ambulance dispatcher to make a decision on the closest hospital, whether it be in time or distance, for emergency calls. That has been implemented and is working very well as far as direction of patients goes.

In other jurisdictions, the same type of problem is rampant. I'm sure you've seen those headlines in various other places. It's rampant that there's a problem with delays at emergencies. But also, redirection is rampant in other places. We've solved that; they haven't. As far as the delays in emergency departments go, we've looked at other places. There are other places that have decided to go in different directions, and nobody has really resolved it. There was one in western Canada, for instance, that decided to have a nurse on duty in the ER who was ready to receive the patients from the ambulances and would take responsibility for the patients. That's just gone into effect, I believe, in Edmonton, so it's yet to be seen whether or not it's going to be successful. It sounds like a good idea.

In other places, from everything I read—and we read a lot, through the Internet and other places—because of growing emergency visits and fewer beds, or whatever the situation might be, constraints on the health budgets in every jurisdiction have caused this type of problem to be endemic, if you will, in all jurisdictions. What is coming out here, at least with Dr. Schwartz's recommendations, are a few additional ways of looking at things.

One thing that wasn't mentioned earlier was the software distribution of ambulances. You mentioned that: What we are doing with respect to ambulances? Toronto came up with software that would distribute ambulances according to how busy each hospital happens to be. When one is busy, if you've got two ambulances at one, the software automatically comes up and the dispatcher knows that he or she should send the ambulance to the next hospital, assuming it's within the guidelines of the closest available at that particular point in time. That's going to be utilized in other dispatch centres that we have, so we're going to be implementing that within the next year.

The Chair: Thank you for your presentation. You'll be forwarding the documentation to us in the next little while?

Interjection: Yes, we will.

The Chair: Are you leaving or are you going to come back?

Mr. Zimmer: I'm leaving.

The Chair: Just before you go, I wanted to inform members of the committee that it's Susan's last meeting with us. They're switching the clerks around, which is a normal phenomenon, to give them experience in each place and so she doesn't become too familiar with the members of the committee as well. Susan has done a great job for us, particularly this summer in terms of our being the host of the conference for all of the public accounts committees across Canada. So Susan, thanks very much for all your work on our behalf, and we wish you well on the general government committee—is that it?

The Clerk of the Committee (Ms. Susan Sourial): That's it.

Applause.

Mr. Patten: Where is the public accounts meeting this year?

The Clerk of the Committee: This year it'll be on Prince Edward Island.

Interjections.

The Chair: I thought you were going to actually express some interest in what the deliberations might be.

We're finished—well, with the Hansard.

The committee continued in closed session at 1228.

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