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(Hansard)**

P-5

**Journal
des débats
(Hansard)**

P-5

**Standing Committee on
Public Accounts**

2017 Annual Report,
Auditor General:

Ministry of Health
and Long-Term Care

Cancer Care Ontario

1st Session
42nd Parliament

Wednesday 31 October 2018

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Mercredi 31 octobre 2018

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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON PUBLIC ACCOUNTS

COMITÉ PERMANENT DES COMPTES PUBLICS

Wednesday 31 October 2018

Mercredi 31 octobre 2018

The committee met at 1230 in room 151, following a closed session.

2017 ANNUAL REPORT, AUDITOR GENERAL MINISTRY OF HEALTH AND LONG-TERM CARE CANCER CARE ONTARIO

Consideration of section 3.02, cancer treatment services.

The Chair (Ms. Catherine Fife): Good afternoon. I'd like to call this meeting of the Standing Committee on Public Accounts to order. We are here today to consider section 3.02 of the 2017 report of the Office of the Auditor General of Ontario, which deals with cancer treatment services.

We have representatives here from the Ministry of Health and Long-Term Care and from Cancer Care Ontario this afternoon to answer the committee's questions. Thank you for being here with us today. I would like to invite you to introduce yourselves for Hansard before you begin speaking. You will have 20 minutes collectively for an opening presentation to the committee. We will then move on to questions, where we will rotate back and forth between the government and opposition caucuses in 20-minute intervals. This session, we will be beginning first with the official opposition for the 20-minute cycles. Please begin when you are ready.

Ms. Helen Angus: Thank you very much. As you know from last week, my name is Helen Angus and I'm the Deputy Minister of Health and Long-Term Care. I'm very pleased to be returning to the Standing Committee on Public Accounts to talk about the report on cancer treatment services.

The Chair (Ms. Catherine Fife): Could I ask you to move the mike closer, please, and to speak up? We unfortunately have to have some fans going, so it's hard for us to hear.

Ms. Helen Angus: All right. If I turn the chair a little bit, I'll be able to get closer. There we go.

I'm joined by Lynn Guerriero, who is the assistant deputy minister of the Ontario Health Insurance Plan division at the Ministry of Health and Long-Term Care. She was the executive lead of the audit when she was responsible for the oversight of Cancer Care Ontario.

I'm also joined by Dr. Michael Sherar, president and CEO of Cancer Care Ontario. Dr. Sherar is also an affiliate scientist at the Techna Institute at the University Health Network. He's also a medical physicist.

We have a number of other ministry and Cancer Care Ontario staff here who will be able to answer more detailed questions about specific programs. As you know, this audit was quite far-reaching in terms of dealing with a number of issues, and so those have different accountabilities in our two organizations. We will introduce them to you as you ask questions.

As always, I want to thank the Auditor General and her team for the audit. I'd say that we had an excellent relationship with Gigi Yip and her whole team in the course of the audit, and I commend them for the work—and the value of the report in terms of guiding our work going forward.

I actually spent 10 years working at Cancer Care Ontario, so it's a topic that I have some passion and interest in, and so I'm going to steal a little bit of Michael's thunder in terms of describing the burden of cancer, just so that we have a level set here. It is the second leading cause of death in Canada. One in two people are expected to be diagnosed with cancer, and one in four actually succumb to the disease. Over 90,000 new cases of cancer are expected to be diagnosed in 2018, and the number of cases is expected to rise by 40% within the next 15 years, so it's really important that we do this job right and that we do it well.

Cancer treatments have improved, and patients are living longer. That's really the good news. Most of the survival improvements have been in people between 40 and 79 years old, but it means that as people live longer, we have more of what we call prevalent cases: the numbers of people living with cancer who come back into the system on occasion and need re-treatment or have longer-term consequences from their disease. In fact, we often think of cancer, coming back to the topic where we were last week, in some ways as a chronic disease now for many people. For those living with cancer and their families, cancer treatment is really life-altering. It really can affect not only their quality of life and the length of their life, but their economic participation and involvement in the community.

As you know, the cancer care system is really a partnership between the Ministry of Health, our agency, which is Cancer Care Ontario—we'll probably call it CCO going

forward—as well as the many hospitals, community providers, dedicated physicians and other clinicians who work in the cancer system.

Under the direction of previous governments, the ministry has worked to improve cancer treatment services through a number of initiatives that are developed, coordinated and integrated by Cancer Care Ontario, which is really pursuant to its role enshrined in the Cancer Act as our chief adviser on all matters related to cancer.

CCO develops clinical standards, plans cancer services to meet patient needs, funds hospitals, collects data that enables improvements and puts that in the hands of the clinicians in order to actually make the improvements that need to be made.

We have provincial screening programs for breast, colorectal and cervical cancer. In fact, CCO is piloting a small-scale screening program for patients at high risk of lung cancer. The real goal of these programs is to stop cancer in its tracks, to catch it before it has even been developed and to reduce the overall number of people who have a diagnosis of cancer.

I just want to talk a little bit about how CCO does this work. We've talked about regional cancer centres, but there is also something called a regional cancer program—I think it's an important concept—where there are networks of hospitals and other agencies that are involved in providing a full range of cancer services, from prevention to screening, diagnosis and treatment and other support services, many of which are actually the subject of the audit in front of us today. They are provided in each of the 14 local health integration network geographies. Each one is led by an Ontario regional vice-president.

Created and funded by CCO, these regional programs are responsible for implementing the provincial standards for programs of cancer care and making sure that service providers meet the requirements and targets set out in their partnership agreements. We've got a number of levers that I think are really important for quality improvement here in the cancer system.

I would say that Ontario patients receive very good care—not only from their individual clinicians, but also from a team. It is a team-based sport, and I think it's important that we acknowledge the many players in the system. Each brings a specific set of expertise that intervenes collectively and consecutively in a patient's journey. I think that even more striking than the number of practitioners who care for cancer patients is the extent of the collaboration between them. You've certainly done some very interesting work over the years in terms of patient journey maps and looking at all the numbers of players who play a role and how the hand-offs in the cancer system are among the best that we have in the province and, certainly, the way that one clinician's expertise then helps the next step in the process to actually do a better job.

But I would say, as in all areas of health care probably, there's always room for improvement and to make care even better. For that reason, we always benefit from the

work of the Auditor General and certainly take the recommendations very seriously. I hope that you see through this that we've actually made considerable progress.

This one has 18 recommendations. They're substantial and, as I say, quite far-reaching in terms of improving and renewing the cancer treatment system. They've already helped us make improvements both at CCO and the ministry. We're going to talk about those recommendations in some detail.

We would be delighted to talk more about the work that has been done on stem cell transplant. I think you can see that considerable progress has been made on the expansion of capacity in Ontario. Wait times are down. Definitely, as of 2018, patients were waiting an average of 3.7 weeks for an allogeneic transplant. This is down from 12 weeks in February 2016 and well below the target. I think we have actually only sent one patient out of country this year. That's a remarkable improvement over a period of a couple of years.

New stem cell transplant facilities are being built in Ontario. The first wave has begun to open: a new facility in Toronto and increased bed capacity in Ottawa. New facilities are also planned in Ottawa, Hamilton, Toronto and London.

On radiation treatment: In response to the recommendations, we are working together with CCO to reduce the geographical barriers.

On cancer drugs: The ministry has already streamlined some of our application processes for the Trillium Drug Program. We're trying to reduce paperwork for Ontario patients, and we're making sure that patients have safe access to the right drugs when they need them. There has been some work done at the Ontario College of Pharmacists around labelling and also dealing with the safety and dosing of cancer drugs.

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On diagnostic services: We've expanded access to PET scanners in the province and are working with CCO very closely on that in terms of new indications and new nuclear isotopes. Again, as research emerges to support new types of PET scans and PET scanning, we will be having that promptly reviewed by expert panels and steering committees to make sure that we're implementing changes at pace for Ontario patients. While progress has been made, I know that there is still a lot of work to be done, and we are committed to doing that.

At this point, I would like to turn it over to Michael to provide some remarks from the CCO perspective.

Dr. Michael Sherar: Thank you. Good afternoon and thank you to the deputy minister for her comments.

I'd like to start by thanking the Auditor General of Ontario for her audit of cancer treatment services in our province. These reports are tremendously helpful to us. At Cancer Care Ontario, we welcome the insights, recommendations and advice of the Auditor General. Audits such as these hold us accountable and transparent to patients, to the health care system and to the public. They also provide an opportunity for us to reflect on our progress and identify opportunities for improvement.

In 2012, there was a value-for-money audit that the Auditor General carried out on Ontario's cancer screening programs that found that sound processes were in place, but also identified areas for continued improvement in our screening programs.

I am, once again, encouraged by the findings of this 2017 value-for-money audit on cancer treatment services, which similarly highlighted that effective procedures and systems are in place to ensure that most cancer patients receive treatment in Ontario in a timely, equitable and cost-efficient manner.

This audit also identified areas to improve the quality and performance of Ontario's cancer system. We agree there is need for improvement in these areas. There are areas where we are already taking measures in partnership with the Ministry of Health and Long-Term Care, and I will be pleased to answer your questions today regarding all of that work.

As the deputy minister has said, identifying emerging issues in cancer care is more important than ever now that there are, for the first time in the history of Ontario, more people over the age of 65 than under 15. This reflects Ontario's growing and aging population, and it will have a tremendous impact on our health care system as the incidence of cancer and many chronic illnesses increases with age.

As the deputy minister has mentioned, more than 90,000 new cases of cancer are expected to be diagnosed in 2018. To meet the challenge of this increasing need, we must continually strengthen the system to be more effective and more efficient.

Despite the growing burden of cancer, Ontario's cancer system is performing well. In 2010, the International Cancer Benchmarking Partnership found that Ontario's cancer system is doing as well as and/or better than many other systems around the world. New data will be released next year, and we are confident that it will show similarly strong results for our province relative to other jurisdictions around the world. Survival for nearly all cancer types is improving, and mortality rates are declining for breast, colorectal and lung cancers, as well as most other cancer types.

While cancer survival is a key measure of the effectiveness of our health care system, our goal at Cancer Care Ontario is to ensure that everyone in Ontario has the ability to access the services that they need, and that they're not disadvantaged from attaining their best possible health because of who they are, what their circumstances are, where they live, or what health condition they have. Health system investments through CCO are focused on supporting this goal in cancer and in renal care, which we also oversee on behalf of the province.

We're also focused on supporting improved access to care for other key health services through our data collection and reporting. As a purchaser of health services, CCO's 2018-19 budgeted investments will include:

- \$416 million for cancer drugs;
- \$403 million for cancer surgery;
- \$181 million for chemotherapy treatment;

- \$141 million for radiation treatment; and

- another \$141 million for cancer treatments, such as for acute leukemia, neuroendocrine tumours and sarcoma.

CCO's approach for performance and quality improvement across our system is built upon four key areas and aims to ensure that these investments that are made are used to meet the needs of all Ontarians in the most effective and efficient way.

The first of these four areas is the use of high-quality data, which enables Cancer Care Ontario to measure and identify opportunities for cancer system improvement across the province, to measure the quality of cancer care, look at evidence from around the world and benchmark Ontario's cancer system against other jurisdictions.

The second is a commitment to planning, to provide focus and direction on the priorities that will lead to system improvements. These are known as the Ontario cancer plans. They serve as our road maps for how Cancer Care Ontario will work together with health professionals, organizations, cancer experts, patients and families and the government to prevent cancer while improving the quality of care for current and future patients. The Ontario cancer plans are developed transparently, through extensive consultation with our many partners and stakeholders, including patients and families from across the province. They're renewed every four years, with the fifth Ontario cancer plan scheduled to be released in early 2019.

The third area is a strong link from CCO through the implementation of the provincial cancer plan right down to the local level of health care providers, with a clear chain of accountability. This includes a quality council at the provincial level focusing on performance metrics across the system, a clinical council which recommends clinical policies and improvement plans for the cancer system, and a provincial leadership council with regional vice-presidents who are responsible for coordinating cancer services in each region and who guide the implementation of the provincial plan at the local level.

Finally, this is tied together through rigorous performance management and improvement. A key component of CCO's approach for performance and quality improvement is that the funding provided for cancer services is through a contract directly linked to the adherence of these standards and the quality improvement agenda that's laid out in the Ontario cancer plan.

In our experience, it's only when all of these levers for change that I've talked about, including the payment for services, are managed and working together in a coordinated way that steady and measurable improvements are made. With this approach in place, and in partnership with the Ministry of Health and Long-Term Care, we believe we can address the challenges and opportunities for improvements as identified by the Auditor General of Ontario.

We will work closely with the Ministry of Health and Long-Term Care and our many partners in our continuing efforts to provide Ontarians with access to high-quality and continually improving cancer treatment services.

The Chair (Ms. Catherine Fife): Thank you very much. You came in under your 20 minutes. That's wonderful.

We will begin with opposition member MPP Morrison.

Ms. Suze Morrison: My first question is related to the take-home cancer drugs.

Specifically, the audit notes that there's a need for process improvement around how patients access funding for those take-home cancer drugs. The report notes that through the Exceptional Access Program the processing time is about three days and through the Trillium drug benefit program it's about 19 days.

But my question is actually in relation to those patients who would benefit from that treatment, who are seeking access for those funds, but because of access through the Non-Insured Health Benefits program—which I do understand is a federal program. There's not a comparator to ensure that there's equity in access for folks who may be seeking funding through a federal program because they're Indigenous. Particularly of concern is when we add the northern and rural context, appreciating the costs of transporting folks out of remote First Nations communities into centres where they would receive in-hospital treatment instead of the take-home cancer drugs and the costs associated with that transportation to make sure that there is equitable access.

1250

Again, appreciating that the NIHB is a federal jurisdiction piece—these things overlap and we want to make sure that Indigenous people aren't falling through the cracks in our system just because we have overlays of provincial and federal program streams—my question is, what work is under way at the ministry to ensure coordination and equity of access?

Ms. Helen Angus: This is where I get to call up my very competent ADM responsible for drugs. This is Suzanne McGurn. Suzanne is executive officer for the Ontario Public Drug Programs and actually plays a substantial role across the country in terms of the purchase and work with other jurisdictions around the availability of drugs.

So I might kick it to Suzanne.

Ms. Suzanne McGurn: Thank you very much for the question. I'm pleased to be able to say that the disparity that you're describing is perhaps not as marked as you might imagine. In Ontario, the public drug programs for any Indigenous individual who has a health card are actually first-payer unless requested by the individual to bill the federal plan as first-payer. As a result, any of the processes that are gone through for any Ontarian would look identical for an Indigenous individual. That would include seniors. They would have the same level of co-payments for individuals between 25 and 64. It would be the same.

The other thing in the work that we do collectively with our jurisdictional counterparts through the pan-Canadian Pharmaceutical Alliance is that we do negotiate our agreements, for the most part, collectively across the country. NIHB: I certainly can't speak wholly on their

behalf, but I can say that they participate in those negotiations and they pretty much match—if I bring on a drug, as an example, in Ontario for cancer, they will introduce it at the same time so there isn't a disparity.

For individuals who may not have a health number or may prefer NIHB to be their first payer—I can't speak to those circumstances.

Ms. Suze Morrison: Thank you so much. That's really good to hear.

My next question, again, is also related to the Indigenous population. Again, appreciating that we see higher cancer rates in Indigenous people and higher mortality rates as well—I'm not sure that I necessarily saw that population piece in the audit. I know that there are some specific Indigenous programs through Cancer Care Ontario, specifically the Aboriginal patient navigators, and there is an Aboriginal cancer strategy, as well. I'm just wondering if you could speak a little bit to what extent those pieces informed this audit, and if there were any other opportunities for improvement in those program streams, as well.

Ms. Helen Angus: I'm not going to speak for the people who did the audit, but I think Michael, as the CEO of Cancer Care Ontario, can talk a little bit about the work done in Indigenous cancer care.

Dr. Michael Sherar: Thank you very much for the question. It's a very important one that speaks to our goal to make sure that the health system and the cancer care system meet the needs of everyone in Ontario. You're absolutely right that the barriers that First Nations, Inuit, Métis and urban Indigenous peoples face are substantial. The burden of cancer is growing at a faster rate in those communities across Ontario.

Our approach, faced with that information, is to say that we need to understand what are the things that we can do to make our system more effective for First Nations, Inuit, Métis and urban Indigenous peoples, as we do for other vulnerable populations. In many cases, it needs a targeted approach because the solutions that might be helpful for me or for you or for anyone else might be different, and they are different, in many cases, particularly for Indigenous peoples.

In that vein, we, as part of the Ontario Cancer Plan, have an Aboriginal cancer strategy, and it's also going through a period of renewal. As you have mentioned, that plan has a set of strategies specifically targeted at making sure that our cancer system is effective for Indigenous peoples across Ontario.

It includes things like specific leadership in every region. We have an Aboriginal clinical lead as well as an Aboriginal patient navigator in every region, working with the regional vice-president, and a terrifically good program at Cancer Care Ontario led by Alethea Kewayosh, who leads our Aboriginal cancer control unit. And so that provincial plan, working with the regional programs, linking with communities across Ontario—with putting things in place that make sure that our system can be more accessible and more effective for those communities.

I think a major piece of that strategy that we undertook over the last several years was to make sure that our partnership with those communities was developed in a way that was effective for those communities. That, from our perspective, really meant, under Alethea's leadership, connecting with those communities, listening to them, and understanding what their priorities were. And they may be different across the province for different communities.

In that context, we established relationship protocols with all of the major First Nations, Inuit and Métis Indigenous groups across Ontario. That really sets the foundation of how we're going to work together based on, really, a contract of mutual partnership and trust as to how we're going to work together.

It has been terrifically important for us to then, in that context of trust, develop solutions together that are going to work for those communities, and I think we're starting to see the fruits of those. Of course, eventually we would like to see that accelerating burden of cancer mitigated for those communities so that we don't increase the gap that's already there between Indigenous communities and the general population in Ontario. We want to close that gap, so it's a set of strategic efforts to achieve that in Ontario.

Ms. Suze Morrison: Thank you.

The Chair (Ms. Catherine Fife): MPP Gélinas?

M^{me} France Gélinas: The very first recommendation that the auditor made was to increase the accessibility of radiation services to patients who do not live close to a radiation centre. It goes directly to my heart.

The answer to this was that CCO has updated the 10-year capital investment plan. Can you talk a little bit as to how we do this? How do we make sure that the people whom I represent have equity of access to radiation treatment?

Dr. Michael Sherar: I'm happy to answer that. Thank you very much for the question. Of course, capital capacity for radiation therapy is critical for access to radiation therapy. I'll tell you a little bit about how that works, but in a general context, when we do that capital planning, we have to balance the ability to provide high-quality care with providing it across the province. As I think you know, in that context, because of the complexity of the delivery of radiation therapy, we have it in a relatively small number of hospital facilities across the province. That tries to make that balance between quality of care and being able to provide safe and effective care for patients, understanding that if we do that, some people have to travel for that care, and making sure that we get that balance right with, again, a large level of input from providers and stakeholders in that delivery of care across the province.

We do, as part of that work and to make sure that we have the capacity in the province that we need and at the right places, develop a 10-year strategy for the province. The last one has just completed, and we've just delivered a new 10-year strategy for the province which really lays out from now until 2028 what we believe, based on forecasting of cancer burden in the province, the need, this balance of providing as much care as close to home as

possible, but consistent with high quality, where one needs a critical mass of infrastructure.

1300

M^{me} France Gélinas: So am I allowed to dream that the plan would see new sites having radiation bunkers?

Dr. Michael Sherar: The new plan does certainly have the set of what we think will be the new number of linear accelerators—these are the units that provide radiation therapy in the province—and recommendations about where they should be located. That's a mixture of bunkers which house the linear accelerators. For radiation safety, they're contained in concrete bunkers.

Some of those are available in the province right now, and so the plan is a mixture of filling those bunkers that are available and new sites. The plan that is in front of the Ministry of Health right now has recommendations for that which the ministry, I'm sure, will consider in the context of its overall capital plan.

M^{me} France Gélinas: Have you had an opportunity to have discussions about this plan since you've brought it forward?

Dr. Michael Sherar: We just brought it forward, so it's very recent. We're just starting to have those discussions with the ministry. As you may know, we have an ongoing plan for replacement of capital as well, and that happens every year, but we will be undergoing those discussions with the ministry, particularly with respect to major and new construction that might be needed to realize what's in that plan, which has a long planning horizon. We will be in those discussions with the Ministry of Health.

M^{me} France Gélinas: When you put those plans forward, do you cost them out?

Dr. Michael Sherar: There are two costs. There is the cost of the linear accelerators themselves, which is relatively easy to calculate. The costing with respect to the construction that needs to be done, if it needs to be done, is something that's primarily under the purview of the Ministry of Health, which manages the construction costs and the planning with respect to that. So we work in partnership with the ministry but we certainly provide, and can provide relatively easily, costs with respect to the equipment itself.

M^{me} France Gélinas: Then, to the deputy: We know that many expenses have had—the government uses a pause button. They have been put on pause. Is the review of the 10-year capital investment plan submitted by CCO one of those that has been put on pause, as with everything else?

Ms. Helen Angus: Well, I think we're looking at our whole capital plan, but I would say we're not going to be in a pause for very long, if we have been. I think we have actually seen some projects go forward. I would highlight West Park as an example. I think we just broke ground on that. There are a number of other high-priority projects that we know are essential to the health of the province of Ontario and we're prepared to advance those regardless, I think. I haven't had a chance to look at this specifically, but we will do that in very short order.

M^{me} France G elinas: Okay. Recommendation number 2 was “implement a program to increase physician awareness of the availability and benefit of radiation treatment.” Could you describe to me a typical physician who needs to have an awareness of the availability and the benefit of radiation treatment? Who are they?

Dr. Michael Sherar: I’ll make a brief comment at the start and then I’ll introduce my colleague, Dr. Robin McLeod, who is our vice-president of clinical programs and quality initiatives, who can talk a little more about the details of that.

Just in general, given that we do have radiation therapy facilities centralized, for good reason, in a smaller number of centres because of the critical mass issue, the challenge of making sure that patients who would benefit from radiation are able to access it—there are a number of factors that influence that. One of them is to make sure that physicians are well-connected and aware of the benefits that they might have for their patients, and that all of the things that can be put in place to make sure that the patients do in fact access that treatment are put in place.

At that point, I’ll perhaps ask my colleague Dr. Robin McLeod, who’s the leader of our clinical programs, including our radiation therapy program, to talk a little bit more about the details of how we go about letting the physicians who might benefit from that.

M^{me} France G elinas: The question was, who is the typical physician to whom you have to increase “awareness of the availability and benefit”? What do they look like? Where do they live? Who are they?

Dr. Robin McLeod: Probably you know that radiation can be the primary treatment for cancer; or it can be given as an adjuvant, when patients have surgery, and then they have radiation; or they might have it in combination with drugs and radiation. Although I can’t say this for sure, that we dove into it, it is likely that the patients who are having radiation as adjuvant therapy are more likely not to get it. That may be because they are not referred by their doctor, or it could be that they are referred but they decide that they don’t want to have radiation, or they may be referred and may decide that they don’t want to have radiation because they live far away from the site.

M^{me} France G elinas: But the answer to this recommendation from CCO was “implement a program to increase physician awareness of the availability and benefit of radiation treatment.” Who do you focus this program to? Who are those physicians?

Dr. Robin McLeod: They could be quite a range, from primary care physicians to, say, surgeons who do not refer someone on for radiation. It may be those types of people.

M^{me} France G elinas: Have you started this program? Does it look useful, helpful? Is anybody interested in it?

Dr. Robin McLeod: Yes. What we’re doing right now is looking at factors of who gets radiation and who doesn’t get radiation.

The Chair (Ms. Catherine Fife): There are two minutes left in this question set.

Dr. Robin McLeod: The only other thing I should mention is that there are also changes in how we treat

patients. For instance, in rectal cancer, there is some discrepancy because of recent evidence that perhaps patients with rectal cancer should not get radiation. So it is a bit of a moving target in that way as well.

M^{me} France G elinas: That brings me to the third recommendation from the auditor, which says “monitor reviews of radiation treatment plans to determine whether the reviews are done in accordance with clinical guidelines.” Your answer to that was that treatment plan disease-specific guidelines were to be completed by March 2019.

Dr. Robin McLeod: Yes.

M^{me} France G elinas: The first thing is that I’m a little bit surprised that we don’t already have guidelines, because I know we do. Are we still meeting the targets? And what are those new guidelines going to focus on?

Dr. Robin McLeod: Right. So peer review is a little bit different than I think you’re getting at. It’s for patients who are getting radiation. They are reviewed by a second physician or group, and it’s the plan to make sure that there isn’t any problem with not giving the treatment in the way that it should be given.

It’s important to point out that Ontario is one of the first jurisdictions in the world to have a peer-review process like this. Right now, about 80% of patients who have radiation have this peer review to make sure that it’s given as it should be.

The Chair (Ms. Catherine Fife): Thank you very much. Now we’ll go over to the government side. MPP Miller.

Mr. Norman Miller: Thank you for coming in today. I’ll start by saying that I have a friend who has had cancer for seven years. I was talking to him a day or two ago, and he was complimenting the treatment. He said how first-rate it was and how impressed he was with the whole system. I don’t think he was expected to live seven years when he started his treatment, so you’re doing some good work.

I wanted to start with recommendation number 11, which is on page 164, to do with positron emission tomography scans. I note in the report it says, “In 2015, CCO estimated that about 50% of patients with aggressive lymphoma could have benefitted from a PET scan to determine the stage of their cancer, but only 14% received one.”

1310

It goes on: “Ontario performed fewer PET scans per 1,000 people” than any other Canadian province.

On that topic, I have a specific constituent issue— who’s happy that we’re using his name, actually. I have a constituent who has met with a number of executives from both the Ministry of Health and Cancer Care Ontario about access to PET scans. Andy Harris of Bracebridge was denied a PET scan which his specialist requested. Mr. Harris has a complex metastatic adenocarcinoma of unknown origin and has been undergoing various surgeries and treatments since June 2016. His case has been described by his doctors as extremely unusual. When he was denied a repeat PET scan—he’d already had one—

Mr. Harris took it upon himself to research the process and to advocate for himself. After a great deal of work on his part and his doctor's, he eventually received one. But most people undergoing cancer treatment wouldn't have the energy to do the work he did, and to ask surgeons to appeal the rulings is not a good use of their valuable time. Despite his ongoing fight, Andy has put a great deal of energy into trying to inform changes within our medical system so that no one else falls between the cracks like he did.

The auditor says that Ontario has not updated PET scan eligibility criteria since 2013 and that Ontario does the fewest PET scans per capita of any province in Ontario and fewer than many, many other countries.

What have you done since this report to improve access for patients like Andy Harris? In the response to the auditor by Cancer Care Ontario, you say you are working to "identify and address potential barriers to patient access." Is the PET panel process one of the barriers you're looking at? What are you doing to ensure patients like Andy receive the scans they need to fight their cancers in the future?

When I met with him, the part that surprised me was, his specialist, who knew him intimately—and he obviously has a pretty rare type of cancer—recommended a PET scan, thought it would be beneficial. Then the PET panel, made up of, I think, three doctors who wouldn't know him nearly as—I was just surprised that a specialist would recommend it and it would be turned down, and that only through a lot of digging did he eventually get it approved. And it was beneficial.

Anyway, I'll leave that with you to comment on.

Ms. Helen Angus: Maybe we'll start with what the ministry has done, and then we can go to the medical physicist who actually knows the technology.

Ms. Lynn Guerriero: I'm pleased to start, and I'm pleased to let you know that I was one of the individuals Mr. Harris met with on his journey.

Mr. Norman Miller: Thank you. I appreciate that, and I know he does, too. He said that he felt that he was making a difference by participating.

Ms. Lynn Guerriero: We don't get to speak to patients directly a lot at the Ministry of Health, so I always really love it when a patient reaches out to say they could help the system and takes the time to do so. I actually spent quite a bit of time with Mr. Harris, as did Dr. McLeod. We'll probably speak to the process itself and how CCO runs the panel and why there may have been a differing perspective on—one physician believing that the PET scan was appropriate and another may not.

I'll let CCO speak to the process itself, but with respect to patient access, I think the beauty of the PET program, the way we've set it up, is that there is a stream of care, I'll call it, where approved indications for a PET scan that are insured services under the OHIP program are done through CCO and funded that way, and patients get access to those. There's also a stream for what we call uninsured PET, where we can look at emerging evidence much more quickly than we may have in the past in order to allow a patient to have a PET scan where perhaps the evidence

isn't as strong that it's appropriate but there is emerging evidence. CCO has done a great job collecting that evidence and then suggesting where an uninsured PET service, for example, should become insured. So we actually have two streams so that patients have better access where the evidence perhaps isn't as strong and is emerging. That's the good news on that story.

With respect to Mr. Harris's feedback on the process of going through that, we actually did make substantial changes to the process. So it was nice that some patient feedback was received, and we actually were able to improve the process based on his experience through the journey.

I'll ask Michael to talk about the process and the panel and how decisions are made with respect to access. Robin may want to speak to the specifics around Mr. Harris's feedback.

Dr. Michael Sherar: Thank you very much for the question. I'll talk briefly about the process, but I'll let my colleague Dr. McLeod talk about the details.

I did want to kind of give some overall context which I think is behind both your question and Mr. Harris's experience. It does reflect trying to strike a balanced approach to having standards for the province, where we know that procedures are of value to patients, and making sure that when evidence is strong our system is receptive to that and we introduce things as quickly as possible that are of value to the patients and to the province. We are continuously working to try to improve those things, and patient input to those is very helpful and crucial.

The balance comes when evidence is not so clear, particularly where we have a resource in the province that is complex to provide and is provided in a small number of centres, and the question of whether or not it's of value to patients. Primarily, the value question is, if you do this scan, will it have any effect on the decisions that are made with respect to that patient and the patient choices for treatment?

There are several areas in PET scanning where that evidence is evolving. We have created mechanisms in the province to provide access for patients where that evidence is evolving. We do that through registry trials, and that's relatively straightforward for us to do where those particular procedures have Health Canada approval. But we also look at new, emerging technologies for PET scanning and new tracers that are used to inject into patients that don't have Health Canada approval. We can bring those into the province or access them potentially in other provinces through what's called a clinical trial application. That's when the evidence is even less, but we can still provide access to those through an emerging-evidence approach. Part of that approach, when we do that in Ontario, is to measure that evidence as we go along to determine whether this particular scan, in general, is of value to patients.

Then, even further—as in the example that you've identified where there's a patient who, with the specialist's knowledge, doesn't fit into any of those categories—what are the processes that we have in place for those kinds of

exceptional access and making sure that those work smoothly? I can't really comment on the particular case—but making sure that there is an opportunity for special cases to come forward where that's appropriate to provide access.

We are, as an agency that oversees now all components of the PET program in the province, trying to make sure that we strike that balance of providing health services that are of value to the population, that those resources are used effectively and efficiently for the province, but at the same time meeting the needs of patients across the province.

Maybe I'll ask Dr. McLeod to talk a little bit about some details of the process and what we've done. As the Auditor General rightly points out, there are lots of opportunities for improving that whole process in what is a complex and fairly rapidly evolving area of care, which we want to keep up to date with, but we don't want to be providing procedures through the health system to the general population where they're not of value for the patient.

The Chair (Ms. Catherine Fife): We will need you to reintroduce yourself once more please for Hansard.

I just want to point out, that was one question, and now we're at 10 minutes, so you have 10 minutes left. I want to make sure that all committee members have their opportunity to speak. I wonder if the answers could be a little bit more succinct, because I know that members have a lot of questions. Thank you.

Please go ahead.

Dr. Robin McLeod: Okay. This is Robin McLeod from Cancer Care Ontario.

I just want to mention a couple of other points before I answer about this one. That is, I think here in Ontario, because we only have an insured PET scan available if it meets our criteria that, in fact, it is so we can ensure that it is done appropriately, or that it's done for patients where it will make a difference: That is why our numbers are lower than other provinces, because we don't want to be having PET scans done when it's not appropriate. That's all based on the evidence and the trials that we do—we've done 12 trials—as well as some of our evidence-based learnings.

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Mr. Norman Miller: If I may interrupt on that, is this a common situation, where the specialist who is looking after someone is looking for a PET scan and unable to get it?

Dr. Robin McLeod: No, because we have the insured ones that are built on strong evidence, and then other ones where the physician can ask for a review for that. In this situation, the patient or his physician asked to appeal it, really, and then we had another group of physicians look at it. When we turn down a PET scan, it is often that we've not got enough information or whatever. So we'll review it, and the majority of those are then recommended.

Mr. Norman Miller: Thank you for that. I'm now going to go to recommendation number 9, to do with symptoms. I note in the report that "51% of lymphoma patients, 47% of colon-cancer patients who received in-

hospital drug therapy, and 44% of breast-cancer patients visited hospital emergency rooms at least once during their treatments," and a number of people returned twice and some three times. My question is, what is the cost associated with cancer patients who return to the emergency room versus how much it would cost to implement an after-hours consistent symptom management program similar to other jurisdictions, such as a hotline, oncology support through Telehealth or other resources?

Dr. Michael Sherar: Thank you very much for the question. We have had a focus on symptom management for several years, for the reasons that are contained in the data you proposed in your question. Cancer treatment is complex. The side effects are sometimes serious, either from the disease or from the treatment. We want to ensure, if we can, that patients don't inappropriately end up receiving care in an emergency room that's inappropriate, or hospitalization. Are there things that we can do in the system to strengthen symptom management for patients either at home or where they live, or in an outpatient setting?

The particular thing that you have referred to is something that we have been exploring, at the moment, through a telephone triage system for cancer patients across the province. In fact, I think we've signed a contract with a provider to do precisely this.

Our estimates are that if you just look in financial terms, which isn't the only factor here, it will have a return on investment, just for emergency rooms, of about a factor of three to four, so that the amount expended on this, if it works as we hope, will result—and this has been shown in pilot studies—in a number of less emergency room visits that would result in a financial savings of about three to four times the investment. So we will measure that. We're going to roll it out more substantially across the province now.

The benefits, of course, are not just financial. This will be better care for patients. They'll have a better experience of their care if we're able to manage symptoms in a better way in the community setting.

Mr. Norman Miller: Thank you. I'll pass it on to my colleague.

The Chair (Ms. Catherine Fife): MPP Wai.

Mrs. Daisy Wai: Yes. Very quickly, one is for my riding in Richmond Hill and the other one is for the wait times referring to surgery.

For my riding: I understand that 14 of them are regional cancer centres. A lot of the cancer patients from York region would think that they would still have to go back to Princess Margaret to get the treatment. They think that they have better treatment there.

How can you correct this? How can you reassure them that, whether they're in York region, in Durham, in Peel or wherever, they will still receive a similar kind of treatment? Because travelling time all the way to downtown will be a strain on the patient, as well as the family members. How can we reassure them, or what have you done? How can we spread this information so that they are not as worried?

Ms. Helen Angus: That's the whole point of the regional cancer programs. Michael?

Dr. Michael Sherar: It's a very good question. Thank you for the question. As you know, in the past, we have had a smaller number of cancer centres in the province, some—Princess Margaret, Sunnybrook, Ottawa, London—with international reputations, and the other legacy centres as well.

As the population of Ontario has grown and the need has increased, we have, over the last 15 to 20 years, seen an expansion of the number of cancer centres across the province, including several in the 905 region: in Mississauga, in Newmarket and in Oshawa. Part of the challenge there when these centres initially opened was to assure people that the standards that we set for care across the province are there for everyone in all of the cancer centres, and that generally, for cancer care, if you go into the centre at Trillium Health Partners or at Southlake or in Oshawa—I'm talking about those three in particular—you will receive the same quality of care as if you had come to Sunnybrook or to Princess Margaret.

One of the ways in which—

The Chair (Ms. Catherine Fife): There are two minutes left in this question set. Sorry to interrupt.

Dr. Michael Sherar: —we tried to ensure that people were comfortable was that when those centres opened, they opened in partnership with Princess Margaret hospital and Sunnybrook, so that there was a planned approach to which patients needed to come to Princess Margaret and Sunnybrook, for example, because there are treatments that are provided there that are of such complex nature that they're not provided in the other cancer centres. But the vast majority of care can be provided at a high standard in those centres. That has largely happened. I think that, by and large, physicians and, through them, their patients are more and more comfortable with that approach, a common standard of care across the province.

Mrs. Daisy Wai: Maybe I'll just quickly say, are there any facts? Can you make sure that you share that information or promote this within those regions so that they will not be worried that they are not receiving quality care and that it is just the same whether they're travelling to other parts or not?

Dr. Michael Sherar: We would be happy to do that. We look at the data of referral patterns all the time to make sure that we're not having people inappropriately, say, come downtown who don't need to be. The centres are looking at this data all along.

Ms. Helen Angus: Some of that, just to add, is probably reported in the Cancer System Quality Index, actually. It looks at the standard of care and how we're doing against guidelines. So there is a place where it's publicly reported. Has it been promulgated as broadly? We could have a discussion about that. But there is a lot of good data there.

The Chair (Ms. Catherine Fife): Thank you. That is—

Mrs. Daisy Wai: Can I just quickly ask my second question and then he can answer later?

The Chair (Ms. Catherine Fife): You have 20 seconds. Ask it quickly.

Mrs. Daisy Wai: Okay. There are wait times for surgery. We know that, in recommendation 2, we have some recommendations. What have you done, and do you think there are other better ways of doing it? Can you share that with us?

If he cannot finish it now, can he finish it later?

The Chair (Ms. Catherine Fife): You can't finish it now. We'll have to come back to that later. And then next up on this side will be MPP Parsa? Yes.

Okay, official opposition: MPP Gélinas.

M^{me} France Gélinas: I will come back to PET scans because, as you know, I live in northeastern Ontario, the only part of the province that still doesn't have access to PET scan technology, 10 years after every other area of the province has been covered. I just had to put that on the record.

Going from there, maybe my first question will be, how come we let an entire geographical area of our province have no access for so long? Where does equity of access come in when new technology is being considered by CCO?

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Dr. Michael Sherar: I'm happy to take that. PET scanning has evolved very rapidly, particularly in the last 10 years. I certainly understand your frustration. We haven't had, over the long history of the province, a specific strategy around the capital for PET scanning in the province. This has been relatively recent, over the last several years. In fact, many PET scanners were traditionally purchased through foundation funding and hospitals.

As the need has increased, we have had a focus initially on trying to make sure that patients have access to PET scanning in light of the capital infrastructure that we have in the province. As that has been consolidated in terms of the registry trials I talked about and the insured part of the system and consolidating this under one program, the Ministry of Health has asked us for a longer-term plan as to the issues of capital and where these machines are and plans for implementing new and replacement machines in the province. We're providing that advice now to the Ministry of Health.

I think for the future we hope that we'll have a longer-term strategy in place to ensure that the machines that we need are in place in the province and that they're in the right places.

M^{me} France Gélinas: Thank you. Recommendation number 1 from the auditor basically says, "streamline and expedite the processes for adopting and funding new radioactive tracers in PET scanning, including updating the eligibility criteria for OHIP-insured PET scan services."

The answer from the ministry surprised me to no end. It says, "The eligibility criteria for OHIP-insured PET scan services is contained in the schedule of benefits for physician services. Any changes to the schedule are dependent on the timing of an opportunity to have discussions with OMA." Really? We cannot add any new areas

of the body that get covered by PET scans until you have an OMA agreement?

Ms. Helen Angus: I'll let the general manager of OHIP answer that question. It's a complicated relationship with rep rights and other things.

Ms. Lynn Guerriero: I'll start by saying I agree with you. This is a bit of a legacy piece, where—we just talked about how PET scans were introduced in Ontario and us trying to have tight reins around the clinical indications for which we would accept a referral for a PET scan. Within that context of introducing new technology in a very careful and structured way—this was before my time, but my understanding is that it was felt that the best way to limit the ability for any physician to just order a PET scan and have a patient receive it was to limit it within the schedule of benefits such that it was specifically indicated which indications a physician could bill for for reading a certain scan. That legacy piece is where we find ourselves today where, in the schedule of benefits, that still exists.

Where we have an additional indication that we wish to say is insured, it means that we have to change Reg. 552 of the Health Insurance Act, and we have to do that change with consultation with the OMA. It's a legacy piece that I think all parties would agree is probably no longer appropriate. I can tell you that all of the parties are working to fix that.

In the meantime, I'll give you an example of a work-around we've done: Acknowledging that—and I won't get into the detail; that can be Michael's job—PET using rubidium, which is actually a cardiac and not for cancer, is something that we've wanted to say is insured but we haven't been able to change the regulation, so, in fact, we've agreed that it can be funded as an uninsured service but publicly funded. That funding is flowing through CCO, and we have implemented that now. The OMA has understood that and agreed to it.

Once we get out of the relationship issues that we're in right now with the OMA and we have a better way of doing housekeeping items to the schedule of benefits, this will be on the list of things that we clean up and perhaps change the schedule to something more along the lines of, you can refer for a PET for appropriate indications as set as out by Cancer Care Ontario—I'm making this up right now—then that would be a CCO list of recommendations that physicians would then have access to.

M^{me} France Gélinas: Wow. Good to know. The answer to the same question by CCO said that CCO completed additional milestones related to the initiation of a registry for a prostate-specific membrane antigen—PSMA—PET scan. Do you anticipate it to start in the fall of 2018? Have we started?

Dr. Michael Sherar: I will ask my colleague, Dr. McLeod, to give the precise details of where this particular tracer is at.

Just to follow up on the last question, the problem that you talked about was related to schedule of benefits. It's when something transitions from one of our registry trials that we manage at Cancer Care Ontario, which are funded

into the insured part, which we also manage. So it's a transition from one to the other.

This particular tracer that you're talking about is a new one, and I'll let Dr. McLeod explain exactly where that one is in terms of having it available in Ontario.

M^{me} France Gélinas: Am I right to think—so you have a registry, it looks like it should be added and you're in negotiation with OMA. So it goes into negotiations, but then you found some workaround. Or could you just keep the registry?

Dr. Michael Sherar: Yes. It doesn't mean that access has to be cut off for that tracer in Ontario. But when something reaches the level of evidence that it should be insured, we would like to move it over there as quickly as possible. That's where that issue comes into play.

This particular tracer is a new one, which is promising with respect to prostate cancer. This issue with the OMA won't be an issue with that one.

M^{me} France Gélinas: So the question is—I hope the answer is very brief—have we started?

Dr. Robin McLeod: Do I have to say, “This is Robin McLeod,” again?

The Chair (Ms. Catherine Fife): Yes, you do. Thanks.

Dr. Robin McLeod: It's a new tracer and it has to be approved by Health Canada, and that's where it is right now.

M^{me} France Gélinas: So the answer is, “No, we have not started?”

Dr. Robin McLeod: We have, but that's where it slowed down.

M^{me} France Gélinas: Okay. Are there patients right now getting PET scans for prostate—

Dr. Robin McLeod: Yes. Yes, there are.

M^{me} France Gélinas: There are?

Dr. Robin McLeod: There are a few that we have sent out of country because we do not provide it here.

M^{me} France Gélinas: Because you don't have the okay from Health Canada to use the tracer?

Dr. Robin McLeod: Yes.

Dr. Michael Sherar: That's right.

M^{me} France Gélinas: How long do those things usually take?

Dr. Robin McLeod: I can't answer that. I'm not sure. I don't know.

M^{me} France Gélinas: Long?

Dr. Michael Sherar: No, not necessarily. These are the clinical trial applications, so they're not notice of compliance necessarily, which is a full approval. These can be under a clinical trial application, but it's a more complex process, that process, where a tracer doesn't have that.

M^{me} France Gélinas: Okay. I am switching gears completely and going into recommendation number 3 that deals with patients having equitable access to take-home cancer drugs. The auditor makes reference to other jurisdictions that have added to their formulary for all take-home cancer drugs. Is there any work being done within the ministry right now to look at, given the—and you give us the number of hundreds of millions of dollars that we spend, \$416 million on drugs, which you said in your

opening statement. How much more would it be to cover take-home cancer drugs? Let's start at that.

Ms. Helen Angus: I must say, as I was prepping for this, I did not know until we started to do our homework that we actually spend more on take-home cancer drugs than we do on cancer drugs provided in cancer centres and in hospitals. I think maybe Suzanne can talk about some of the improvements that have been made both for providers and also for patients.

The Chair (Ms. Catherine Fife): Suzanne, can you please introduce yourself for Hansard again?

M^{me} France Gélinas: So my question, Suzanne—am I allowed to ask you, Suzanne?

Ms. Suzanne McGurn: Yes.

M^{me} France Gélinas: Okay. My question is, how much more would it cost to have, like other provinces have, covered take-home cancer drugs versus all of the wonderful programs that we now have? How much more would it cost to have take-home cancer drugs covered?

Ms. Suzanne McGurn: Suzanne McGurn, assistant deputy minister for the Ontario Public Drug Programs and devices.

The costing for that has not been done in the recent year. It has been done previously and asked about in previous estimates etc. Depending on how that might be approached, the costs can range from approximately \$100 million to multiple hundreds of millions of dollars.

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The reason that that is important is—just as an example, the deputy has reflected on the growth. The growth is most rapid not just in oral chemotherapy agents, but other important cancer medications that individuals take as supportive care. Just for example: Since the auditor report was done, there have been 43 new molecules or indications for cancer added. Of those, almost half of them have included oral cancer medications. There certainly has been significant advocacy around this topic. The costing that was done at that time perhaps does not fully recognize the full span and the long-term implications.

I would also just add to that, in the opening remarks that were given by both Dr. Sherar and the deputy, they spoke about cancer in the aging population. Remember, the next 10 years will see an approximately 44% growth in seniors. It's not just the immediate year; it is the long-term sustainability.

M^{me} France Gélinas: But aren't people over 65 covered anyway?

Ms. Suzanne McGurn: They are, but I think it is one of those things where we do have to be doing our planning for the drug program you spoke about from the perspective of all existing. So there is a combination of that. That growth will continue.

Lastly, I don't think it would be inappropriate to comment that cancer agencies generally are dealing with very significant pricing in drug costs. At the point in time when other jurisdictions may have made this choice, circumstances might have been quite different. We are starting to see different paces of new drugs being added

across the country, as influenced by the overall cost. It is a multi-faceted, complex piece of work.

M^{me} France Gélinas: I agree. Every new drug is \$100,000 per course of treatment or more. It blows my mind. But anyway, go ahead, Deputy.

Ms. Helen Angus: That's fine. I think that Suzanne answered it. Is there anything else that you wanted to know?

M^{me} France Gélinas: I realize how complex it is, but am I the only one who sees that there is a body of evidence growing to show that you achieve better outcomes in provinces that have made the decisions to cover take-home cancer drugs versus—we'll take Ontario, where all of us get constituents coming to our offices because they have been prescribed take-home cancer drugs that they can't afford. Now, we start to go through Trillium, through whatever, helping them through. If anybody wants to answer that, go ahead.

Ms. Helen Angus: I'll ask Dr. Sherar to talk a little bit about the assertion around outcomes. I would say it's pretty obvious that there's a conversation in this country about the cost of drugs. We're certainly part of it. But there are a lot of factors, as Suzanne suggests, in terms of the numbers and costs and where we can best apply our dollars. That's the kind of work that we're doing at the ministry on a regular basis in the drug program and elsewhere.

Certainly, the federal government has indicated its great interest in expanded access to drugs. It's not my job to make the policy, but it will be interesting to see what their contribution to that might be.

With that, I'll hand it over to Michael.

Dr. Michael Sherar: Thank you for the question. Oral cancer drugs are a standard of care, and they're increasing as a proportion of new drugs that are coming into the system. We're getting more and more drugs that are oral and less that are delivered intravenously that are new coming in over time.

There are certainly issues with respect to access, quality and safety that are as important for oral cancer drugs as they are for intravenous drugs. It's not only a question of access, which is an important one. I would say, by and large, if you look across the country, Ontario does well with respect to access to cancer drugs. There is quite a variation across the country.

But we recognize that there are significant issues. The Auditor General has commented on these in terms of areas where we do need to strengthen our system, with respect to quality, safety and access with respect to oral cancer drugs. You know the policy implications are significant, and this is being debated not only with respect to cancer drugs but all prescription drugs across the country, in lots of debates.

You're correct that some provinces have chosen to say, for cancer drugs and not other drugs, "We will have this approach where we centrally manage it and bring it into the public system." Others are approaching it a different way.

As an agency, we are certainly providing advice with respect to issues of access, quality and safety. We do need to strengthen our approach in Ontario to those issues for oral cancer drugs. We're working hard with the Ministry of Health on what the solutions can be in the context of policy decisions that are taken federally and provincially. We can make progress with respect to these issues and we're committed to doing so.

M^{me} France Gélinas: Okay. The second recommendation of the auditor on that topic was to "simplify and streamline the request and application process for financial support for cancer drugs." The answer from the ministry was that you were looking at evaluating the feasibility of adding take-home cancer drugs to the telephone request service as a pilot project to bridge SADIE implementation, and it's aiming to be implemented by the end of 2018. Do we have telephone requests for this for cancer drugs yet?

Ms. Suzanne McGurn: Again, thank you for the question. The answer to your question is yes, we have started telephone request services for a select group of medications. I apologize that I cannot list them off the top of my head for you, but that has started and we are working hard on that.

We've also worked on another number of initiatives that were identified, both as part of the audit as well as continuously looking at how do we do our job better. That starts with everything from the fact that the actual applications have been difficult—so working with individuals to figure out where are the gaps in the forms. We've worked on streamlining. We've worked with the Ontario chapter of the Canadian Cancer Society to answer many questions that routinely come up so that they will have that information.

The Chair (Ms. Catherine Fife): There are two minutes left in this question set.

Ms. Suzanne McGurn: With regard to the question about SADIE, which is the Special Authorization Digital Information Exchange, that work is well under way in the ministry. We actually do have a large group of clinicians, who we fondly talk about as our friends-of-SADIE clinicians, who are very interested in supporting and effectively implementing new tools that will allow for more complete applications to be provided. The audit pointed out approximately 17% to 20% were submitted incomplete, which resulted in delays in being able to make a determination of whether the drug would be funded. I think we will have clinicians starting to work with the tool and see its prototype at this point in time, and whether it will meet their needs as early as next week. I'm pleased to report that significant progress continues on that work.

M^{me} France Gélinas: Yay!

With SADIE, they will do it online, and with the telephone requests, they just phone up. It's a list of drugs. Physicians would know that for this list of drugs, you can phone and gain access to the Exceptional Access Program, and for others, you do it online.

Ms. Suzanne McGurn: We work very closely with the cancer agencies and the hospital pharmacies as well to be able to answer those questions about how people contact us, and for which drugs.

The other thing that has changed since the auditor did their audit is that our information is much more publicly available through the e-formulary lookup tool, as well as the list of all the EAP drugs, not just those for cancer, with criteria that were not previously in the public domain.

With regard to the telephone response, it's for a select group of drugs at this point in time. Once we get SADIE in place, it should fill the need for many of the drugs. It would probably be best characterized as, we will have drugs where, once the information is able to be inputted, there are very specific criteria. We are looking at those not in this first pass, but as the prototypes roll out.

The Chair (Ms. Catherine Fife): Thank you very much. I was trying to let you get to the end of that sentence, but it kept going on.

Ms. Suzanne McGurn: That's okay.

The Chair (Ms. Catherine Fife): Thank you very much.

Do you want to continue? I think you should restate your question, though, and then we'll go to Mr. Parsa immediately.

Mrs. Daisy Wai: Basically, it's just wait times, wait times, wait times—especially on surgical treatments. I also want to highlight the centralized referral and what better ways you can also suggest there.

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Dr. Michael Sherar: Thank you for the question. One of the focus areas for all of our programs is access, wait times and the experience the patients have in accessing treatment services. Surgeries are one area that the Auditor General noted.

In particular, cancer surgeries are broken down into more or less urgent. By and large, the overall performance of the system in Ontario has been improving steadily with respect to overall access to cancer surgery and patients being able to meet those wait-time targets or be seen before a wait-time target.

The biggest challenge is with the more urgent cancer surgeries, where we set a target of 14 days between the time that the surgeon says that a surgery is appropriate for this patient and is urgent and when that surgery should be done and they should be in the operating room. Of all our categories—so that's category 2. There's emergency, which is category 1; the urgent cases, priority 2; and the less urgent cases are categories 3 and 4, which are one-month and three-month target times. Overall, we're at about just under 90% of all patients in Ontario reaching their target. The lowest performance we have is with that particular category, where I think we're around 70%. So just over two thirds of all patients are meeting that target, but we recognize that some patients do not and that there's variation across the province and there's variation across hospitals and across disease sites—particular types of cancer where this is more of a problem than in others.

We work through our regional programs, and we have a provincial cancer surgery lead who works with regional cancer surgery leads in every region. They work with all of the local hospitals, and we provide data and information, as detailed as we possibly can with respect to what

the issues are that you're dealing with in your hospital and how we can understand why some patients are not meeting that target, and we have regular reviews, both regionally and with those hospitals.

Given the Auditor General's noting of this in her report, we've strengthened those efforts this year with respect to better analysis and better information as to precisely what the reasons are why people don't meet that 14-day target. Quite a lot has to happen in those 14 days. It's the most difficult of the targets to meet. Nevertheless, we want to see that increase up towards the levels that we have for the other priorities across the cancer system.

It's really performance management, understanding the data, understanding the information and making sure that hospitals have the resources, which we do through our specific cancer surgery funding in the province, where we have the resources we need to fund those procedures. It's more of an issue of capacity and process, of being able to meet those timelines and making sure that we have the supports through engagement and through data and information to increase that performance. We'd like to see that happen.

The Chair (Ms. Catherine Fife): Okay. MPP Parsa?

Mr. Michael Parsa: Thank you, Deputy. Given the shortage of time, I'm going to be very, very specific with my question. It's regarding wait times for stem cell transplants. In February 2016, wait times were twice as long: 12 weeks instead of the six weeks that were targeted. How did the ministry deal with this important issue and what has been the impact?

Ms. Helen Angus: Yes, I would say that there's been a fairly rapid and important expansion in capacity to repatriate patients and have patients treated in Ontario. You'll see, from what Lynn describes to you, that the wait times have come down substantially.

Maybe you want to just hit some of the highlights?

Ms. Lynn Guerriero: I'll maybe go through how we achieved what we did. It was a multi-pronged approach. If you think back to—it was early 2016 when we sort of hit the peak of where we realized that we were not going to have the capacity required for the population that needed stem cell transplants.

I want to differentiate, before we go down this road, that there are different types of stem cell transplants. The autologous type, where you're getting your own cells transplanted, was not the issue. We were able to achieve those within clinically appropriate benchmarks. It was the allogeneic transplants where we had the issue, and that was through a donor. It could be a related donor or an unrelated donor. It's the most complicated type of stem cell, and that's where we were having the issues.

So we did a few things. We convened what we called the stem cell consultation group, which is a very large table of people. It pulled together all the people in the province who do this work, with respect to the senior administration from the hospitals that do stem cell transplants, as well as the clinician leads or the transplanters from those facilities, and then a number of people from Cancer Care Ontario and a number of people from the ministry. That group advised us on how to move very, very

quickly to increase capacity in Ontario and also streamline the process for moving people out of Ontario through our Out of Country Prior Approval Program.

We knew we would never be able to build the capacity inside the province fast enough to achieve the capacity we needed, so we needed to use our out-of-country outlet, which is an outlet that exists, but we needed to expedite that process in some way.

With respect to bricks and mortar and beds, I would say that the group quickly came to agree on a number of capital expansion projects. There are a small number of hospitals in the province that do this particular type of transplant: Princess Margaret, Ottawa and Hamilton. London does a small, small, small volume. So it wasn't a lot of hospitals that we were actually looking at—bricks and mortar—but there was very, very fast planning around increasing bed capacity.

The other capacity issue we had with respect to hospitals was actually human resources. We quickly found out that there was no way we could rely on just the physicians, the complex malignant hematologists. They're very few in number, and if we were relying on the current model of care and only hiring or recruiting additional physicians, we would not be able to achieve the capacity we needed.

We did a tremendous amount of work on looking at other models where we would actually be looking at nurse practitioners, physician assistants and different models of care to change the model so that we could be transplanting more people within the resources that we had. We also changed the funding formula to make sure that hospitals were appropriately resourced not just for the transplant itself, but for the care patients required pre-transplant and post-transplant. It's a very complicated course of care, not just the transplant itself.

I already mentioned the out-of-country valve, that we had a very rapid approval process that was developed by CCO and their partners within the hospitals.

Lastly, we did make a decision to open a new acute leukemia program at Sunnybrook, so to open a second program in the GTA, because Princess Margaret was particularly overwhelmed. Sunnybrook, actually, is opening their new acute leukemia beds next month. The beauty of that is it's a partnership with Princess Margaret. It's sort of a single program across two sites. We've alluded to that in the past, that we don't just have a hospital start a new technology without help from their colleagues. The Sunnybrook program will start with treating acute leukemia. They will then move to doing auto transplants and will then move to do allo transplants.

Those are the various valves we used. I think Helen said in her opening remarks that we took the wait times from about 12 weeks down to about four weeks. It's below four some months and above in other months, but it's around four, so well within the six-week time frame. We had over 80 patients waiting during the height of the crisis, and now we have about 30 patients who are waiting to get their stem cells but getting them within that four-week time frame. So it's a good achievement, and we've not sent anyone out of country in a number of months.

Mr. Michael Parsa: Thank you. A very, very, very specific question on the topic that was discussed earlier, the PET program: How does CCO, in particular, analyze this and ensure that this is an evidence-based program, the PET program?

Dr. Michael Sherar: Thank you for the question. We do this in the same way we do with our other programs. We convene a panel of experts, and this is a wide array of experts. It's called the PET steering committee. They look at evidence both in Ontario in terms of the programs we have for registry trials, and from around the world, as to new indications and when the evidence reaches a threshold where it can be moved over into the insured part of the system.

We rely on those experts for their advice in terms of the strength of the evidence and what should be our priorities for provision and providing access in funding in the province of Ontario.

1400

Mr. Michael Parsa: Okay, thanks.

The Chair (Ms. Catherine Fife): MPP Surma?

Miss Kinga Surma: I just have two questions. Ontarians who do not receive Ontario Drug Benefit benefits may need to apply for the Trillium Drug Program in order to receive funding for cancer drugs. Can you please explain how that program works?

Ms. Helen Angus: For sure, and I can ask Suzanne to come up and talk about some of the mechanics. It's a drug benefit program that kicks in and provides access to the Ontario Drug Benefit Program for people who have high drug costs relative to their income. It actually has a sliding scale of deductibles dependent upon your income, and I think you've done some things to make it easier for people, and cancer patients specifically, to apply to that program. It's roughly between 3% and 4% of your net income. It happens to be line 236 on your tax form that actually is the determinant of what your contribution is before the Trillium Drug Program kicks in.

Maybe Suzanne can explain it in a little more detail.

Ms. Suzanne McGurn: Hi. Thank you very much for the question. I appreciate the opportunity to talk about the drug programs.

Just a small bit of context: I would say that it's important to recognize that we spend almost \$6 billion on drugs, serving many millions of Ontarians. There are six main programs through which we do that. They're programs that people are quite familiar with, covering seniors, individuals who are on social service etc.

The Trillium Drug Program is probably best characterized, as the deputy indicated, as in other jurisdictions—referred to as their catastrophic drug program. For individuals under 65 who have traditionally benefited from the Ontario Drug Benefit Program, it provides them with a valve, whether they have private insurance or not, for the circumstance when their drug costs become significantly impactful on their household. It is a scale that sits at about 3% to 4% of your household income. It may surprise you that for individuals with private insurance, as an example, as private insurance may split costs 80-20—

as a number of insurance plans do—that as these high-cost drugs that were talked about earlier increase, the actual cost of those percentages become quite significant on individual households.

This program is not eligibility based, such as with seniors where on your 65th birthday you are automatically enrolled in the program. It is a program that you actually have to apply to. Any of us in this room can apply for the program. Based on your application that is processed through an external service provider agency, they will complete the information. It takes about nine days for that process to happen, seven days of their time to get the approval. Obviously, whenever there are forms to be completed, there may be missing information and some back-and-forth, so that time period, as I've learned from the auditor—the patient experience may feel much longer than that and may be perceived to take weeks at a time.

Once an individual has their Trillium approval, they will know for that fiscal year how much out-of-pocket costs they have to pay before the Ontario government will kick in and cover their drugs. Each year, if you, as most people do, provide consent, your actual deductible is updated and you are notified. Sometimes those amounts can be quite significant: \$1,000 or \$2,000. A number of years ago, to make that more palatable for individuals, your deductible was divided into quarters so you don't have to pay the full \$1,000 or \$2,000 out of pocket. It is divided up at a quarter and then totalled over the year.

The other thing, particularly in the cancer space, that we get a lot of commentary about—and I think it was alluded to in the opening remarks—is that individuals do start perhaps not being able to work while they're having their treatments. We do recalculate in-year if someone's income has changed by more than 10%. Our systems will then count your claims that you get covered at a pharmacy, and once you reach that deductible amount that you have paid out of pocket, we will start paying.

Miss Kinga Surma: Okay. Because this is a program that you have to apply for, is there evidence, then, to suggest that perhaps there are people who qualify and have not applied because they're not aware? How are people made aware that they can qualify? Is it through their physician? How does that work, exactly?

Ms. Suzanne McGurn: I think with any program that is eligibility-based, until you need it, you often don't know about it, and so I would say that's the first start. As was alluded to earlier on in, I think, one of the questions about drug navigators, in the cancer space, as an example, there's a very well-connected network of individuals who are able to support patients and assist them in answering those questions.

Additionally, the work that's been done with the Canadian Cancer Society, the Ontario chapter—a lot of it is about that being one of the first places that people call with a new diagnosis; that they have the information as well to be able to direct the individuals to how to do this, in recognition that a diagnosis of anything, but in particular cancer, raises a lot of concerns, and so there are people who will assist with helping people through that process.

Miss Kinga Surma: Okay. Sorry, last question: There have been instances of drug shortages. The most recent one that we can remember was the incident of the EpiPens. Do these shortages happen with cancer drugs and, if so, what action is being taken in order to prevent such an instance?

Ms. Suzanne McGurn: Maybe I'll start, if that's okay, and then I'll turn it over to cancer specifically.

The reasons for shortages in the drug environment are complex, and there's no single reason. It can come from overseas manufacturing, where there's been a quality concern identified at a manufacturing plant. It can come from an active ingredient that's required for the product that becomes unavailable, and that may impact worldwide distribution. It may be, in some circumstances, where import requirement questions have been raised by Health Canada. It can be that there has been, as an example, a new indication or new funding coverage and, as a result, you may see a spike in the demand.

As of March 2017, Health Canada requires mandatory reporting of anticipated shortages, and there are hundreds of drugs on that list at any one time. What we do in Ontario is we work closely with our jurisdictional counterparts in Health Canada and our internal colleagues, first and foremost to try to figure out for which ones of those drugs—if they come to be in shortage, because not all of them do, and it would be difficult to plan for that many shortage scenarios—

The Chair (Ms. Catherine Fife): Two minutes left in this question set.

Ms. Suzanne McGurn: —which ones are critical and, for those, what are our alternatives. Perhaps Michael can speak to some of the cancer ones.

Dr. Michael Sherar: I'll be brief and just say that they do have them with cancer drugs fairly regularly, as they do with other drugs, for all the challenges that occur in the manufacturing industry that the assistant deputy minister has alluded to.

I think what the Auditor General has noted is that we do have processes in place to work with hospitals and physicians in terms of what to do in the case of shortages, what we can do in Ontario with the stocks that we have available, what alternative treatments there might be—and there usually are alternative approaches that have good evidence behind them as well. So we are able, in general, to manage these shortages in a way that does not have a significant impact on patients, but occasionally that does happen.

The Auditor General has noted that with all of the processes that we have in place, both within Ontario and working with Health Canada, looking at alternatives, dealing with stocks in Ontario, we can continue to strengthen that approach and mitigate the effects as much as we possibly can when shortages do occur.

Miss Kinga Surma: But what are the processes?

Dr. Michael Sherar: The processes that we have are with our clinical leadership. We have clinical leads provincially and locally for chemotherapy, for example, right across the province, so we can very quickly assess

the situation right across Ontario. If there is a shortage alert coming in internationally or nationally, we can very quickly assess what's the status in Ontario, and what is the likely need and when to introduce, or look at, alternatives. We usually start on that work with clinical leaders in Ontario right away, and look at the opportunities for—

The Chair (Ms. Catherine Fife): Thank you.

Dr. Michael Sherar: —transition—

The Chair (Ms. Catherine Fife): Thank you. Thank you. Extra thank you. That is it.

1410

The good news, though, is that there are 15 minutes left for the official opposition and then 15 minutes left for the government, so please organize yourselves accordingly. MPP Gélinas.

M^{me} France Gélinas: I'll give you time to finish your sentence, because I was also interested.

Dr. Michael Sherar: I was just going to say the types of things we do then. If it really does result in a shortage and we have to introduce alternatives, we look with clinical leaders at prioritizing the patients who need to get the existing stock. We might run into the situation where we say, "Okay, given the stock that's available, we need that for a certain subset of patients; others might have alternatives." We might work with hospitals to transition patients onto those alternatives prior to the drug running out, because we need to conserve it for patients who really will need it.

These are the types of strategies that we can do and put in place quite quickly in Ontario to mitigate the effects of a shortage. We can't avoid them necessarily. Although, we do work with Health Canada, as well as with the Ministry of Health, for example—I don't know what you would call it—in lobbying or advocating for alternative supplies to come into the country or alternative drugs to come into the country quickly. Health Canada is able to do that.

Interjection: Thank you for that.

M^{me} France Gélinas: No problem.

My question is about recommendation number 5 of the auditor:

"To help ensure cancer patients receive safe cancer drug therapy, we recommend that the Ministry of Health and Long-Term Care:

"—work with Cancer Care Ontario to evaluate the need to set standards and oversee delivery of cancer drug therapy at private ... clinics."

My first question is to you, CCO. In the new Ontario cancer plan, are we expecting to see expansion of those private clinics delivering cancer drugs? Is this something that you touch on at all in your plan? Is this something that is there to stay? Are we going to see more of them, less of them, the same?

Dr. Michael Sherar: I don't think we'll see a large expansion. The reason these facilities exist is largely in the cancer—it's not only cancer; they provide infusions of other drugs. But in cancer, largely they're providing infusions of drugs that, through our evidence-based approach nationally and then in Ontario, are not put on the formulary. These drugs are then, I guess, by definition, not

insured. Private facilities are able to provide infusion for that where physicians and their patients still think that drug will be of benefit to that patient.

We have a number of them across the province—in the tens—private facilities that do provide that service. We continue to work with the Ministry of Health to look at the options, as the Ministry of Health is doing, to have some oversight over the quality and safety of the provision of that service, albeit not insured. We're still very much interested not only in the quality and safety of that service that's provided—of course, those patients are patients who we also care for in the public system for all of their other care needs, other than that infusion.

There are often issues with respect to transitions of care back and forth from a private facility, and we want to make sure that if patients are accessing these services, that works well, safely and effectively. It's for those reasons, I think, that the Auditor General has pointed out that we need to look at this—and we are, with the Ministry of Health—in terms of what the options are that we do have for getting a line of sight into the quality and safety of what's being done in these private facilities.

M^{me} France Gélinas: I don't want to put words in your mouth, but is it accurate to say that CCO has no intention of shifting any of the infusions that you do in the different cancer treatment centres and to send them into the community and into more community-based clinics, rather than within cancer treatment centres?

Dr. Michael Sherar: No, we have no plans. The issue around these private clinics and the interest that we have in them is that they are providing these services. We're interested in the quality and safety of cancer care for these patients. No, we have no plans along the lines that you've talked about.

M^{me} France Gélinas: Thank you. To the deputy: How is it going? Are we going to have any kind of oversight of those private clinics?

Ms. Helen Angus: Yes, for sure. There was a fair bit of work done, actually, prior to the election on an approach and modernization of some of our oversight of community clinics writ large, whether they're private clinics or just run by physicians under the Independent Health Facilities Program. We haven't had a chance to bring that forward, but obviously in this area there's a role for public health and there's a role for the College of Physicians and Surgeons of Ontario in terms of their oversight of physician practices and their oversight of out-of-hospital premises. Those are the lines of inquiry that we've done, and we will bring forward some recommendations to the current government shortly.

M^{me} France Gélinas: When you say shortly—before Christmas, or before Easter?

Ms. Helen Angus: I'll have a chat with my minister and we'll get it on the docket for her.

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

I'm going to recommendation number 9—I'm trying to use my 15 minutes wisely—on patient symptoms: A question was asked already, and you answered it. In your answer you said that you have contracted a telephone

service. Who did this contract go to, who are those people, how did they get expertise and how do they connect back to the EMR, the team and everything else?

Dr. Michael Sherar: With respect to the contract, I'll introduce one of my other colleagues, if I may, just very briefly. This is Elham Roushani, who is vice-president and chief financial officer at Cancer Care Ontario. He has actually worked with us for over 20 years, and—

The Chair (Ms. Catherine Fife): Okay. Please come on up.

Dr. Michael Sherar: And he—

The Chair (Ms. Catherine Fife): It's great that you introduce them, but they also have to introduce themselves, so please do so.

Mr. Elham Roushani: Elham Roushani, Cancer Care Ontario.

The Chair (Ms. Catherine Fife): Thank you very much.

M^{me} France Gélinas: So my question is, who is the contract with?

Mr. Elham Roushani: The contract was awarded, after a competitive procurement, to Bayshore.

M^{me} France Gélinas: To Bayshore?

Mr. Elham Roushani: Yes.

M^{me} France Gélinas: And is it province-wide?

Mr. Elham Roushani: It's province-wide. The annual value of the contract is \$1.1 million for taking telephone calls for about 26,000 patients by registered oncology nurses, 24/7.

M^{me} France Gélinas: And how do they link—do they have access to the EMR?

Mr. Elham Roushani: I will defer that to Dr. McLeod.

The Chair (Ms. Catherine Fife): We should get a larger table for next time, perhaps. I've never seen a committee with such musical chairs.

Please go ahead.

Dr. Robin McLeod: There are a couple of things that attract us to Bayshore. First of all, they did do a pilot with 13 hospitals, and we were able to show a decrease in patients going to the emergency room by about 40% to 50%. Of those who did go to the emergency room, for 80% of them, it was the right thing to do, so that was very good.

The second thing is that all of the nurses are oncology nurses, so they work in the various cancer hospitals and sort of do this on the side. They know the cancer system very well. To answer your question, yes, they also have access to the EMR.

M^{me} France Gélinas: Okay. Is it one centralized answering service?

Dr. Robin McLeod: Yes.

M^{me} France Gélinas: So somebody from Gogama will be talking to a nurse in Toronto?

Dr. Robin McLeod: From where, did you say?

M^{me} France Gélinas: It doesn't matter where they are. Where is the person who answers?

Dr. Robin McLeod: I thought that you were saying someone in Africa or India. No, they're not going to be.

M^{me} France Gélinas: Gogama.

Dr. Robin McLeod: But yes, they will be. It's not necessarily in Toronto, but they are oncology nurses.

In the pilot that we did, it started out just with hospitals in the GTA, and as they went along there was a hospital from Windsor, so it has been tried across the province.

M^{me} France Gélinas: Okay. I have to jump to recommendation number 12, so we're now talking about CT scans and MRIs. In the ministry's response you say corrective action to reduce wait times for MRIs and CTs for cancer patients has been taken through targeted funding in 2017-18 and 2018-19. Who got what money, and how come I missed that?

Dr. Michael Sherar: I can probably answer that. We provided advice to the Ministry of Health through our access-to-care program, because on behalf of the province, we measure access to CT and MRI broadly, not just for cancer patients. Given the pressures that we were seeing in MRI—and we noticed them, of course, for cancer patients as well and patients who, through the diagnostic workup for cancer, needed an MRI. We provided the ministry advice on where and how a targeted funding approach might be used and where that funding should go. The ministry did put that in place last year and this year, and we'll talk to them about that for the future. It did work. The wait times for these patients came down by, I think, about 30% as a result of that targeted funding approach. We'll be evaluating it as it goes along to make sure that the targeted funding actually does achieve what's intended here, which is a reduction in waiting for particularly the more urgent scans for MRI access.

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Ms. Helen Angus: You probably don't want us to read it now, and I don't have it with here with me, but we can provide you with—

Interjection.

Ms. Helen Angus: Allison is waiting to jump up.

The Chair (Ms. Catherine Fife): Yes, and why not.

Ms. Helen Angus: Okay. Very good.

M^{me} France Gélinas: How many minutes have I got left?

The Chair (Ms. Catherine Fife): You have four full minutes.

Ms. Allison Costello: I'm Allison Costello, director of the acute and emergency services division.

On the advice of Cancer Care Ontario for providing targeted funding that was one-time to high-risk cancer patients, we provided that funding in 2017-18 and 2018-19 across a number of LHINs and hospitals. We can definitely follow up, because it was targeted to where it was needed most, and we worked with the LHINs to ensure that they had the capacity to take on the extra hours.

M^{me} France Gélinas: But this was one-time dollars? It was not added—

Ms. Allison Costello: It was one-time dollars.

M^{me} France Gélinas: It's one-time. Okay.

Ms. Allison Costello: The advice from Cancer Care Ontario was to provide one-time funding over multiple years to bring us within target within three years.

M^{me} France Gélinas: Okay. I was also interested in the ministry's response. You go on to say: "More broadly, the ministry is also examining ways to use central referral in booking programs to improve appropriateness of diagnostic imaging referrals and reduce demand for growth in MRI and CT scans." How does a central referral in booking bring in more appropriate referrals? What's the link?

Ms. Allison Costello: I can speak a little bit to that. There's a lot that can be done through a centralized process that will embed the evidence into the referral form so that you'll have more information about what scans are appropriate for a primary care provider who is making the referral. That can make sure that the referrals that are received within a hospital or an independent health facility are the ones that should be getting that scan. But additionally, it can bring down the wait times quite a bit because there's not the lost booking of facts and whatnot so that it is directly to the receiving agent, and they're booking it right away.

Dr. Michael Sherar: Yes, exactly. Maybe I can make a quick comment: The issues generally with MRI and appropriateness are not in cancer, and so the first target of this work is on where there might be a higher prevalence of inappropriate scans. That's being done with our help as well in musculoskeletal indications. The reason that central referral in booking can help is because, of course, then there's codified information about what indications are appropriate. The physician actually has to follow a set of guidelines—

The Chair (Ms. Catherine Fife): Last two minutes.

Dr. Michael Sherar: —for that. That's why it can help not only to streamline the process but to make sure that the indications are appropriate.

M^{me} France Gélinas: Okay. I won't have time to do the last one, so I'm going to come back to—the money that you spent for the one-time, you're telling me, had an impact of a 30% decrease in the wait time for MRIs.

Dr. Michael Sherar: For those indications.

M^{me} France Gélinas: For what?

Dr. Michael Sherar: For the indications it was targeted to.

M^{me} France Gélinas: What does that mean? Which indications and what targets?

Dr. Michael Sherar: The funding was specifically targeted not to all patients who might be referred for MRI but those we thought were more important, including staging for cancer patients—those in high-risk breast-screening programs who need MRI. It was targeted at a specific subset of patients who were referred to MRI, and for that group, this targeted funding worked.

M^{me} France Gélinas: So I take it that in this fiscal year that we are in, host hospitals still have this targeted funding for targeted—what happens come April 1?

Dr. Michael Sherar: We're in discussions.

Ms. Helen Angus: Yes. I would say we're just in the early strokes of looking at our multi-year plan, so obviously, we have some decisions to make. But the fact that this has produced results, I think, is quite compelling.

M^{me} France Gélinas: How much money were we talking about?

Ms. Allison Costello: We provided \$4 million in 2017-18 and just under \$4 million in 2018-19.

M^{me} France Gélinas: To how many sites?

Ms. Allison Costello: I can get that information for you.

M^{me} France Gélinas: Okay. And just because I'm running out of time: How many cancer centres have out-patient pharmacies?

Dr. Michael Sherar: Most would have out-patient pharmacies, if not all. They're all integrated with the host hospitals that they're in, which all have, I think, out-patient pharmacies. Robin, do you—

The Chair (Ms. Catherine Fife): Perhaps that information could be confirmed at follow-up.

Dr. Michael Sherar: Yes, we'll find that.

The Chair (Ms. Catherine Fife): Thank you very much. To the government side: MPP McDonell.

Mr. Jim McDonell: Thank you for coming out today. I had a neighbour of mine who had prostate cancer and ended up using robotic surgery very successfully. The doctor went on about all the benefits. You could do the surgery across the room or across the province. The recovery time was much less because, really, there were no incisions.

Are we using it in many places? Is that something we're looking forward to increasing the use of? I imagine the surgery was done in Ottawa, but I'm not sure.

Dr. Michael Sherar: I'm sorry. I missed the first part of the question because I couldn't hear it. It was about robots, was it?

Mr. Jim McDonell: Yes, robotic surgery.

Dr. Michael Sherar: Robotic surgery, yes. That's in place in several centres across the province. The technology is quite expensive, and there's a significant learning curve for surgeons to use that, so it's done in a smaller number of centres across the province. The issue of what's the appropriate place for this in our system is something that's evolving, I would say, in terms of looking at the evidence and seeing where this is of value.

The indications—including in cancer—for this type of surgery are evolving across the province. There are potential benefits, as you say, for patients in terms of decreased length of stay and some potentially lower complications. Looking at the evidence for that and making sure it's of value for patients where it's provided is part of the process that we, in the ministry, are undergoing not only for cancer indications but more generally.

Mr. Jim McDonell: This occurred probably 10 years ago, so it's not something just recently. The explanation by the surgeon was that instead of a one-inch incision, he said, "It would have to be large enough to get my hands in and then I have to see in there." So you can imagine the difference in the incisions.

Also, is there a possibility to utilize this type of technology for remote sites? Anywhere you would have access to—certainly across the city or across the province, in this day and age, where your specialist might be in Toronto or

Ottawa but many of your patients are thousands of miles away.

Ms. Helen Angus: I think there are huge opportunities for—I don't know about robotic surgery, but there are huge opportunities for virtual care. That has certainly got to be part of the work that we do both in cancer and beyond. There are jurisdictions that have a much greater use of virtual care. In fact, if you look at Kaiser Permanente in the US, 52% of their encounters are done virtually. We're less than 1%, so I think that's an area of focus for us, going forward, because it can be more convenient for patients and provide equivalent care.

Dr. Michael Sherar: We regularly look at new technologies, whether it's for surgery or radiation, and what the evidence is for their use. Several innovations are evolving, and we want to be able to look at the evidence. We often run pilots for the introduction of technology. We've done that for several radiation technologies in the province to understand where the benefit is, and when we think about providing it more generally in the province, what the implications are for the operations of hospitals and the human resources with physicians and nurses. All of that has to be worked out.

Having an approach to looking at innovation in the cancer system and more generally is very important.

Mr. Jim McDonell: And I'm sure technology will bring prices down as well. Thanks.

The Chair (Ms. Catherine Fife): MPP Miller.

Mr. Norman Miller: I've just got a few questions. I'll try to be quick. Recommendation 14, which is about page 168 of the auditor's report: Patients waiting to undergo biopsies have a longer wait time than provincial targets; however, biopsies being performed in clinics or hospital procedure rooms are not included in this data tracking.

1430

The ministry's response to this recommendation was that "it may not be feasible" to collect this data. So what barriers deter you from accessing this information? Perhaps you could also talk about strategies to reduce the wait times.

Dr. Michael Sherar: Maybe I'll start. Thank you for the question. It's a very important issue that the Auditor General has raised, where we recognize that we need to strengthen our information with respect to access to biopsy. It can be a bottleneck with respect to the diagnostic work that has to be done to get an accurate diagnosis and staging for cancer to make treatment decisions. We do want to make sure that access to this is good and is seamless.

We are considerably strengthening the information and data that we have with respect to biopsies to create a more complete picture within the operating room where these are done, and outside as well. We want to have that picture so that we can look at opportunities for improvement and to make sure that this particular area of care is working well.

We already have, on the performance reviews that we do of all of our regional vice-presidents, which have a whole set of indicators with which we measure their

individual performance—biopsies are on there now with respect to this issue. And we're looking at ways to expand that data where we don't currently collect it.

Mr. Norman Miller: Thank you. I'm moving to recommendation number 2, on page 143. Why is there such a difference in wait times between hospitals that are close together? I note in the report, it gives the example that urgent breast cancer surgeries between two hospitals just 15 kilometres apart were 30 days in one and it were 14 in the other. Another example was where "gynecological cancer surgery ranged from 12 days at South East LHIN to 74 days at Central West LHIN, compared to the wait time target of 14 days."

I note that some regions have implemented a central referral system for some cancer surgeries. Do you have a perspective on the costs and benefits of this program to illustrate how it could be beneficial here, and is there a plan to make this information public? We had a discussion earlier about having a central referral system and maybe making that information public so that people would know how long it would take for various surgeries in various different LHINs.

Dr. Michael Sherar: Thank you for the question on the cancer surgery issue. You know, I think the point the Auditor General was making was that we can have quite variable performance sometimes in hospitals that are close together and why would there be a difference in performance. We do see variability in performance, and it can be for a variety of factors that are related to capacity, process or leadership in hospitals across the province in addressing issues. We work with hospitals and facilities to understand the reasons why this variability is occurring and regularly review with them to try to make sure that that variability is reduced.

I would say, overall, over time, that variability on the whole for cancer surgery wait times and other wait times in this province is closing; it's not getting wider. But nevertheless, there is variability.

The other point that you alluded to, which is also important, I think, is are there tools that we can put in place with respect to things like centralized referral? Would that make sense across either a group of surgeons or a group of hospitals? I think sometimes the answer to that is yes, and then there's all of the challenges of working with hospitals and providers to put that in place.

Maybe I'll quickly ask Robin if you want to comment on the issue of centralized referrals, specifically for cancer surgeries—

Mr. Norman Miller: And making it public was the other part of that.

Dr. Michael Sherar:—and then publicly reporting on that. I think, with respect to the public reporting, we're committed to reporting data that would be used for patients and families. We provide all of the data that the government provides through, now, Health Quality Ontario, and access to a whole variety of services, including cancer surgery, that's fully transparent to the public. But I think in issues where we manage referrals, say, through a centralized process in a particular region, making sure that

providers and patients and families have that information is important.

Robin, do you want to talk about the issues of centralized referral for cancer surgery?

Mr. Norman Miller: You know, because I have limited time, I'd rather get the questions, at least, on the record. The next question would be—the auditor's report, on page 147, found that Ontario oncologists could have seen an average of seven more patients with the time they're using going through the EAP paperwork; that's the Exceptional Access Program paperwork. What would be the cost-care comparison for a streamlined EAP application, or a longer renewal cycle, versus the care that could have been provided to cut down wait times, diagnostic testing etc.? How many opportunities for care could have been created with a more efficient EAP process? Does the ministry intend to work on a simplified process?

Ms. Helen Angus: I think the short answer is yes. Suzanne has talked a little bit about the phone and SADIE and some of the other things. The return on investment that you're asking for perhaps we can provide to you so that we don't chew up some of your time; it sounds like you've got a couple more questions. We're happy to provide that information to you. Obviously, we've implemented, because we think there is a business case and it makes sense.

Mr. Norman Miller: Thank you. Another question, then. On page 171, it states, "We estimated that CCO overfunded hospitals by about \$12 million for incomplete treatment courses during 2014-15 and 2015-16. Although CCO modified the funding formula in 2016-17 to fund hospitals only when a patient receives care, its contractual agreement with the hospitals has prevented it from recovering the \$12 million."

How did that go unnoticed for two years, and what's the plan going forward to deal with it?

Dr. Michael Sherar: This area in the Auditor General's report I think reflects an evolution of how we pay for services with hospitals across the province. We've transitioned how we pay for chemotherapy across the province from I would say quite a simple approach of a per patient, on an average, of what that patient will need across the province, to a more complex, more sophisticated approach where we're paying more specifically for the complexity of treatment that's provided for each patient across the province.

There's always a balance there, because we don't want to get to the stage where we're trying to calculate the math with every single patient in the province. That would be more than it's worth for everybody in terms of value. We have to strike a balance of being not too simple that we're not supporting the costs in hospitals for the patients as they need them, and not too complex so that it becomes too burdensome.

We are transitioning all of our funding. We've transitioned most cancer surgery now, all of chemotherapy in the province—

The Chair (Ms. Catherine Fife): Last two minutes of questioning, Mr. Miller.

Dr. Michael Sherar: —and we will be looking at radiation therapy as well. So I think the auditor's important note was with respect to, as we've gone through this evolution, looking at where the opportunities are to more closely tailor the funding to the specific needs that we have for cancer patient treatment in the province. We'll be continuing to look at that.

Mr. Norman Miller: Thank you. Throughout the report, there are instances where service providers did not meet provincial targets, including wait times for cancer surgeries; that's on page 143. On what data are these targets created, and what is the accountability framework for them?

Dr. Michael Sherar: I think I mentioned a little earlier that we have four categories of urgency for cancer surgery, and we have set targets by which we expect patients to be able to access, actually, both a referral into a surgeon's office and then, once the surgeon and patient have decided that surgery is appropriate, the time to have that surgery.

Those categories of targets were set by an expert panel, a little like the PET panel that I talked about earlier. This was a cancer surgery panel. They were set some years ago, with respect to what the reasonable targets are to make sure that patients access those services in a timely way

based on the urgency that those patients and their clinicians experience. That's how we ended up with the emergency one, which is 24 hours; urgent care degree is 14 days; care degree III is one month; and care degree IV is three months—and putting the different types of cancer appropriately with that expert opinion.

That looked at two things: one, where there's evidence that waiting longer will have an effect on a patient's outcome, but also on the patient's experience as well, and making sure that those targets were reasonable. They were set through that process. We'll periodically look at them and look at new evidence. If there were new evidence that came out that said we could improve—

The Chair (Ms. Catherine Fife): Thank you, Mr. Sherar.

I want to thank both Cancer Care Ontario and, of course, the Ministry of Health and Long-Term Care for being here, as well as the staff that sat with us this afternoon. Thank you very much.

This committee will now move into closed session, where we will do report writing.

The committee recessed at 1441 and later continued in closed session.

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