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Mercredi 4 novembre 2015

Standing Committee on Estimates

Ministry of Health
and Long-Term Care

Comité permanent des budgets des dépenses

Ministère de la Santé
et des Soins de longue durée

Chair: Cheri DiNovo
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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON ESTIMATES

COMITÉ PERMANENT DES BUDGETS DES DÉPENSES

Wednesday 4 November 2015

Mercredi 4 novembre 2015

The committee met at 1555 in room 151.

MINISTRY OF HEALTH AND LONG-TERM CARE

The Chair (Ms. Cheri DiNovo): Good afternoon, members. We are here to resume consideration of the estimates of the Ministry of Health and Long-Term Care. There is a total of 51 minutes remaining. When the committee was adjourned yesterday, the third party had about 44 seconds left in its question rotation. Madame Gélinas, if you wish, please proceed.

M^me^ France Gélinas: When I was–

Mr. Bas Balkissoon: Time's up.

Laughter.

M^me^ France Gélinas: —interrupted yesterday afternoon, I was asking about the OMA negotiations: if any polling had been done, if any public opinion research had been done regarding the negotiations regarding the OMA agreement, and if so, how much the government spent, and if you could share the results of those, if they were done.

Hon. Eric Hoskins: As you can appreciate, through my ministry, we routinely do polling on a number of subjects, including the provision of health services by our physicians. There has been some polling done over the course of the year—

The Chair (Ms. Cheri DiNovo): I'm afraid that your time is now up, so if you could maybe submit that.

Hon. Eric Hoskins: I was just going to get to the interesting part.

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

Ms. Indira Naidoo-Harris: Thank you, Chair. My question is for Minister Damerla. Minister, as our population ages, more and more families in my riding are faced with finding the right long-term-care homes for their loved ones. Residents want to know that they can live comfortably in their new homes, and their families need to know that they'll be properly cared for.

Many families in my riding who are undergoing this transition are worried. They're worried about the affordability of long-term care. Can the minister please let us know what the government is doing to ensure that each and every Ontario has access to the long-term care they deserve, regardless of their financial means?

Hon. Dipika Damerla: Thank you for that really meaningful question. It's an important question. I just want to begin by assuring this committee, and Ontarians in general, that, in Ontario, no one is denied long-term care because they can't afford it. The way that long-term care works is that there's a small copay that residents pay, and the rest of the expenses are borne by the government. Even that copay piece is geared to income, so depending on what your income level is, the copay is pegged so that affordability is never an issue, and I'm going to go into some detail.

I also just want to say that, overall, we are really proud of the investments we have made, both in long-term care and—what I think of as the other side—home care, because home care and long-term care go hand in hand. The more we invest in home care, the longer people can stay in their homes and the less they need to use long-term care as well. Our investments in home care, in many ways, go towards that affordability issue because, if people can continue to live in their own homes, then they don't have to worry about long-term care, or probably worry about it a little less or for a lesser amount of time.

To that end, our investments in community care have been increased by more than $270 million this year, which is just part of our commitment to increase our investment by over $750 million by 2017. That's over and above the fact that we've added more than 10,000 long-term-care beds since coming to office—and, of course, our commitment to redevelop 30,000 long-term-care home beds.

Coming back to the issue of affordability: As I was mentioning, the guiding philosophy is that income should never be a bar to access to long-term care for our parents and grandparents, and this is why any resident who does not enough income to pay the full copay rate can apply to have their copayment rate reduced.

Just as some background for the committee members: Currently, long-term-care-home residents are required to contribute to the cost of their accommodation—basic or preferred—through a copayment. The ministry determines the maximum copayment rates that long-term-care homes may charge residents for accommodation, as set out in regulations. To ensure that income is not a barrier to access, residents who do not have sufficient income to pay the full copayment rate may be eligible to have their copayment amount reduced. This is known as rate

reduction and is only available to residents in basic accommodation.

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Currently, around 33,000 or 43% of the total number of long-term-care residents in Ontario benefit from the reduced long-term-care copayment rate, to which our government commits between $160 million and $200 million per year. The government covers the copay that the 33,000 residents are unable to pay, that portion.

The 33,000 lower-income residents who do pay a reduced rate are unaffected by any change. Even if we were to change any copayment rates, affordability continues to be maintained. That's a really key part of how we designed copay policy.

To get a sense of how affordable long-term care is in Ontario, I think it would be useful to compare copay rates across Canada. Here are some numbers that show that Ontario is really on the more affordable side. For instance, the Northwest Territories has the lowest at $25.37. In Ontario, the basic copay rate is $58.35. But when you start to compare it with comparable provinces such as Saskatchewan, where it is $67.23; Manitoba, where it's $80.60; and British Columbia, where it is $105.25, you begin to get the sense that Ontario, at $58.35, is very affordable. I think it's a very fair way of setting the copay rate. I hope that answers your question about the affordability of long-term care in Ontario.

Ms. Indira Naidoo-Harris: Thank you so much, Minister, and thank you for the thoughtful and detailed answer. It's very encouraging to know that when it comes to affordability, people out there, regardless of their income, will be able to access the kind of care that they need. I know it's something that families out there are concerned about, and I hear the question come up every now and then.

Putting it in the context of the rest of the country also gives us a sense of how well Ontario is doing to make sure that we are making this accessible for our seniors and for families, so thank you so much for your answer.

I'm now going to switch gears a little bit. My next question, Chair, will be for Minister Hoskins.

Minister, the public health units in my riding provide many of our community health programs, which are vital to my constituents. I'm quite aware of all the great work that our public health units do. They're working hard every day to prevent illnesses and diseases and to protect Ontarians and protect our public health care system.

A key part of this, of course, is education, as you know. I've heard recently about perceived cuts to public health units' funding this year, and I wanted to get further clarification on what our government is doing to support our public health units here in Ontario. What is our government doing to support the hard work that these units do for Ontarians? Can you tell me about the difference in funding provided to public health units from last year?

Hon. Eric Hoskins: Of course, and thank you. I was feeling a little neglected by this side of the table, so I'm glad that I've got the opportunity to answer your questions.

You mentioned hard work in your question. I feel compelled to begin by acknowledging the incredibly hard work of our public health nurses, our public health doctors, administrators, those who work in what I believe is one of the best public health systems in the world. It's one that I'm incredibly proud of.

I think many people know that apart from being Minister of Health, I'm also a family doctor, but few people know that I'm a public health specialist. In fact, it was 30 years ago this year—I missed the reunion; it was about 10 days ago—that I graduated from medicine and made a decision to become a specialist in public health. I have to say, it had a lot to do with the medical program at McMaster University at that time, which provided a lot of time during the course curriculum to pursue individual interests and goals. About a third of the curriculum was elective time, so virtually all of that time—a third of a three-year program—I spent doing public health in different parts of the world: in India and in the Dominican Republic. I know you probably suspect I had other motives going to the Dominican Republic, but in fact, I spent a year there, building latrines and vaccinating kids. This was at the ripe old age of—I think I was 21 when I started medical school, or 20 even.

It's a little-known fact as well that my wife, Samantha Nutt, was originally going to become an obstetrician-gynecologist. It was as a result of my influence—persuasion, I suppose, or maybe simply that at the time, I had practised as a public health physician for more than a decade before I met her, or just about a decade—that she changed that career path, and what she has done is also become a specialist in community medicine and public health.

In 1985, when I decided to pursue that path, little did I know how valuable that experience would be in my current position and, as I mentioned, giving me great confidence in our front-line public health workers and the incredibly critical role that they play every day in keeping Ontarians safe and healthy, and promoting healthy living. They understand better than probably just about anybody the issues of health equity and social determinants of health.

This morning, I gave a speech at HealthAchieve, which is an annual conference by the Ontario Hospital Association. I spoke about how important those issues of health equity and the social determinants of health are to ensuring that we deliver care to those who truly need it, and that we have a broad perspective when it comes to what that support and that care should be. Often it is outside of the direct realm of health care—maybe supportive housing, for example; maybe income support—but it's no less important to helping achieve those healthy outcomes.

Back to 1985, when I decided—I'll say this humbly. I received a Rhodes scholarship to go to Oxford, and it was there that I was able to gain a degree. They call it a DPhil. It's the equivalent of a PhD here, although it's

wholly a research degree. At Oxford, I obtained my DPhil in epidemiology and community medicine. That's what set me on the course to working in Africa and other parts of the world. I did the fieldwork for my DPhil in Sudan, and I lived and worked in Sudan for three years, doing exclusively public health and working in war zones in Sudan and other countries, working with refugees in the eastern part of the country. Gradually, month by month and year over year, I honed my skills in public health and gained a greater understanding of just how vitally important public health is to all of us.

Not wanting to dwell too much on the past, but I wanted to share that with the committee as evidence, I suppose, of how, as minister, it's important for me to look at health care through that lens as well—and the incredibly important work that the associate minister does in health promotion, for example—and how we can, as a government, ensure that we're providing that breadth of services and support, so that Ontarians can avail themselves of a healthy lifestyle and healthy living.

Probably, I think, the goal of all of us is to ensure that Ontarians don't get sick in the first place. It's much better for all of us—including as a society, including from a fiscal point of view—to lead healthy lifestyles; where their health is promoted. To be able to avoid illness and disease is a much better path through life than the alternative.

That's what brings me to present day, I suppose—is that long background of when I was at Oxford. I think I said earlier in the committee, it took me nine years to get my DPhil. I should probably just make it clear that it wasn't because of any negligence, or because it took them four years to consider whether I was really worthy or whether my thesis was substantial enough or not. It was because of a long and winding road, and the three years, that I mentioned, in Sudan that I worked in public health, as well as in Somalia and Ethiopia, and Iraq as well, during and after the first Gulf War.

It really gave me a perspective, not simply being in other parts of the world—but really, that public health perspective of just how vitally important social determinants of health and health equity and issues of access are.

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In public health here in the province today—I've already referenced how incredibly proud I am of our front-line public health workers and the work that they do every day. They're almost unsung heroes, aren't they? They do tremendous work, but it's generally unnoticed. Their job is to prevent the outbreaks and prevent the epidemics, so when they don't happen, we never think back that it was because of the efforts of our public health nurses to ensure that kids are vaccinated against infectious disease. We never make that connection when we avoid a catastrophe or avoid an outbreak or an illness—a food-borne illness, for example. We never think back on how we avoided that because we're not thinking about it anyway, because it never happened. It really is a vitally important part of our health care system.

A few years back, before I became health minister, when it was felt, after a number of years, where regardless of size or need—where we had provided the same increase across the board to all our public health units. We had done that for a number of years without regard, really, to what the community need was and what the population pressures might be and how to best invest the dollars that—

The Chair (Ms. Cheri DiNovo): Just to let you know, Minister, you have about five minutes left.

Hon. Eric Hoskins: Five minutes.

At that time, in fact, there had been a number of studies and reports written to look at, could we do a better job of allocating resources through our public health units, so that they would be responsive to—what we were able to do was measure and identify the needs within the communities themselves. There are certain parts of the province where the challenges that people might face, based on demographics or based on socio-economic data that we might have—we had sufficient evidence to have a good understanding that we could do better in the allocation of resources.

That really was the basis of the reform of the funding formula applied to public health units. This year we had the opportunity, really, for the first time—and I should reference that this is in the context of, the funding that we have provided to our public health units since we came into office in 2003 has increased dramatically. It has increased by 164%, which, as a sector or sub-sector within health care, is probably greater than any other sector or component of the health care system. So we demonstrated our commitment solidly over that period of time.

We felt that we had an opportunity to do better in terms of allocation of new resources, and so that's what we've done this year. As a result of study and consultation that involved AMO, the Association of Municipalities of Ontario; alPHa, which is the association of the public health agencies, who are front-line public health workers—we have a funding review working group that was comprised of a whole set of stakeholders. It was chaired by Dr. David Mowat, who was the acting Chief Medical Officer of Health for Ontario.

There are people in this room who invested a great amount of time into that funding formula. We decided that this year we would have the opportunity to implement it, but only on the increased funding. So that 2% increased funding that we provide and have provided for a number of years to our public health units—we decided for that increase—so the base funding to all public health units we kept intact, but we felt that it was responsible to take that 2% increase in the budget and allocate that based on the new formula, which would allow us, as I mentioned, to begin that process of focusing and targeting those additional dollars where we

can understand and have evidence for where the need is greatest.

That's what we've done this year. I have to say that, not surprisingly, as they have done throughout, our public health units are rising to the challenge and working extremely hard to continue to deliver those vital programs that they deliver on a regular basis.

I hope that begins to answer your question.

Ms. Indira Naidoo-Harris: Thank you, Minister. Chair, how much time do I have left?

The Chair (Ms. Cheri DiNovo): About a minute and a half.

Ms. Indira Naidoo-Harris: Okay. Thank you, Minister. I really appreciate you sharing your experiences and your observations with us. I think that, when we talk about public health, we're talking about prevention, and it's pretty clear that a lot of our focus here in Ontario is on that.

I am particularly interested in the fact that you have had experiences elsewhere, and so probably bring to the table a real sense of the support that Ontario gives to public health in comparison to other places around the world. Do you find that that has really assisted you in being able to see where the needs are and how well we are doing here in Ontario?

Hon. Eric Hoskins: Well, it's clear that we can always do more, right? What I attempted to do in my answer to your first question was reinforce just how deeply committed I am to supporting our public health units. I believe, and we've done considerable work within the ministry as well, that we can take steps to better integrate public health into the overall health care system, that we can certainly benefit from the advice of our public health professionals. As I mentioned, they are experts in social determinants of health and issues of health equity, health promotion. For that reason alone, I think we can and we need to take further steps so that they are part of the decision-making process in the broader health care system, that we can benefit from that expertise—

The Chair (Ms. Cheri DiNovo): I'm afraid you are out of time, Minister.

Now, there being 30 minutes remaining in this ministry's estimates consideration and seeing that we're at the end of a full question rotation, we will split the remaining time evenly. The Progressive Conservative Party is up now for about 10 minutes.

Mr. Michael Harris: All right. Good afternoon, Minister.

We last were speaking about EDS and the working group, and I know your deputy read into the record the folks that are on that committee. If you can submit that to the Clerk for us later, and perhaps the dates that they're going to be meeting, that would be great.

The timeline you've set on it, or actually the actionable items to the group—are they going to report back to you directly on their findings?

Hon. Eric Hoskins: The working group itself?

Mr. Michael Harris: Yes.

Hon. Eric Hoskins: Yes, definitely they will be.

Mr. Michael Harris: Now, I'm kind of moving around, but we did talk about PKU, and you constantly say that you've taken the politics out of these things. What do you mean by that?

Hon. Eric Hoskins: As a government, we took steps to take the politics out of the decision-making with regard to which drugs should be brought into the public drug program. In fact, I believe I have no legislative authority, and I think it would probably be contrary to the act for me to attempt to influence a decision with regard to adding a drug to the formulary—or removing one, I suppose—or making it otherwise available to Ontarians.

As a scientist with, as I referenced, a degree in epidemiology, I have a good understanding of the process that leads to a drug being brought to market, as well as being deemed proven effective for any particular condition. This predates me as minister, obviously, but I have a great understanding of just how important it is for all those decisions to be made based on science and evidence alone. Politicians, I think you'd agree, don't necessarily always have a track record of making decisions on science and evidence.

Mr. Michael Harris: They don't.

I submitted a letter to you back on June 29. Now, I should check with my office; I don't think we've gotten a response. I can give you a copy of the letter, but if you can ensure that I get a response to that letter, it would be helpful.

Moving over to Ornge and the disaster it was, obviously, under the previous health minister, I'm wondering if you can explain this to me. Ornge used to post their financial statements on the website, and I don't believe there were any financial statements for 2014-15. Can you tell us why those were not posted and if you can submit them to the committee?

Hon. Eric Hoskins: I'm not aware that that's the case. Perhaps the ministry might be able to comment on that directly.

I'm also not aware—I thought I was up to date in response to letters, but I'll look into that in terms of a response, and I apologize if you haven't received it yet.

Mr. Michael Harris: No, I'm not suggesting you didn't. We couldn't find it if you did. But, yes, get it to me, I suppose.

So was somebody going to respond to the financial statements of Ornge for 2014-15?

Dr. Bob Bell: We're just getting the person who can give us that data and tell us why that's the case. I wasn't aware of that either.

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Mr. Michael Harris: So there's that. I'm wondering if you could tell the committee, and this would be something you'd submit to us at a later date, but patient transfers for last year—year over year, I guess, so that would be 2014 and then 2015, if they've increased year over year.

Hon. Eric Hoskins: Yes.

Mr. Michael Harris: They have?

Hon. Eric Hoskins: Sorry. Patient transport volumes you're talking about; correct?

Mr. Michael Harris: Are they going up or down?

Hon. Eric Hoskins: From 2012-13, they were 17,832. Today, or rather 2014-15, which obviously are the most recent results that we have, they are 18,035, which represents an increase. Sorry, I should have given you—2013-14, it was 17,603. So it's a 2.5% increase from 2013-14 to 2014-15.

Mr. Michael Harris: Okay. I'm wondering if you can tell the committee if the ministry or another source of government provided Ornge with any one-time funding that would be considered outside of its normal annual funding.

Hon. Eric Hoskins: I don't have the answer to that. I don't know whether the deputy does or if that might be something that we need to look into.

Mr. Michael Harris: Yes, if you could get back to us on that specific question.

Hon. Eric Hoskins: Yes. Can I add as well that on the transport—I know you might not refer to them as patients, necessarily, but organ transport went up substantially as well, a 38% increase. I'm quite proud of that fact. It's obviously a result of the efforts in terms of the Trillium Gift of Life Network for organ transplants.

Mr. Michael Harris: I'm going to give it to my colleague here in a minute, but the last question I had was on your plan for the CCACs and the LHINs. Do you have a plan to merge the CCACs with the LHINs, or do you want to explain if there are any plans to do that?

Hon. Eric Hoskins: The Donner report earlier this year spoke more of function than form, so we implemented a 10-point action plan as a result of her recommendations. Subsequent to that, as you know, there is the Auditor General's report. We have embraced and will be implementing all of her recommendations.

One of her recommendations—I think it was recommendation 5—specifically points to the importance of doing a system review, of essentially looking at our CCACs from top to bottom, from the perspective of the quality of care that they provide to Ontarians. We have not made any decisions in terms of any changes in governance or structure, but as a result of the recommendation from the Auditor General, the ministry is consulting with stakeholders in terms of what those improvements might be. We haven't made any decisions as of yet.

Mr. Jeff Yurek: Thanks, Minister. I want to just ask some questions about the Price report. I think everybody had a copy before it was officially released, and now it's released.

Where are you with reviewing and implementing the Price report, and are you taking steps to fully implement it?

Hon. Eric Hoskins: The Price report, as you know, looks at primary care reform. It was provided to me earlier this year. It's a public report. I would say it's important to the government. It's one of a number of reports and pieces of advice that we've received from stakeholders in primary care. One of the reasons to make the report public—last month, I believe—was to invite responses from our stakeholders. We haven't made any decisions based on the report as of yet. Perhaps I'll invite a follow-up question.

Mr. Jeff Yurek: No, I was just focusing mainly on the patient care groups that may be created. Is the ministry costing out what that would cost to maintain and how many patient care groups per LHIN would be created? Have you gotten that far or are you still at the preliminary review?

Hon. Eric Hoskins: I don't think anybody should assume that we're necessarily implementing any, let alone all, of the Price report recommendations. It's an important report and it is guiding our work going forward, but what we aren't going to be doing is creating another layer of bureaucracy. Fundamental to any decision-making process is the element of choice, both for the patient as well as their health care providers.

Mr. Jeff Yurek: I don't have a lot of time left. Just a question with regard to cancer treatment: Is the government taking a look—and maybe your deputy minister may have to respond—at increasing the amount of oral medications for cancer treatment to be reimbursed in the community as opposed to focusing clearly on the IV medication?

Dr. Bob Bell: As you know, many of the oral medications taken by cancer patients in the community are funded through the Trillium program, where patients have catastrophic expenses related to illness. Many of the cancer drugs that people gain access to through the Exceptional Access Program are funded in the community. Of course, the 60% of Ontarians who have access to private drug plans have those funded—oral medications—in the community.

Cancer Care Ontario is providing us with advice regarding the potential. The investments that we've made in injectable drugs are substantial. Under the New Drug Funding Program, the costs in 2014-15 represented an 18% growth compared to 2013-14. The products that have been approved for the—

The Chair (Ms. Cheri DiNovo): I'm afraid your time is up. We need to move on to the third party.

Mr. Michael Harris: Can you make a note, Chair, of the questions that were not able to be answered?

The Chair (Ms. Cheri DiNovo): Yes.

Madame Gélinas.

M^me^ France Gélinas: Given that this is my last opportunity, my first question is about PET scans for the northeast. Everybody in the northeast working on this file is under the impression that it's not going to cost the ministry any more money to send a mobile PET scanner to Health Sciences North than what is already spent. Are you budgeting money for a mobile PET scanner or do you take it that it's not going to cost the ministry anything for us to have a mobile PET scanner come to Sudbury?

Hon. Eric Hoskins: Thank you for asking this question and thank you for your advocacy as well on behalf of the residents of Sudbury and the area.

I think you know that earlier this year I went to Sudbury to have conversations about their request for a PET scanner—or late last year and earlier this year. As a result of those conversations, I asked the Ontario PET scanner expert—

M^me^ France Gélinas: PET scanning committee.

Hon. Eric Hoskins: —committee to provide me with their advice. Fortunately, in Ontario I believe the average wait time for getting a PET scanner, including Sudbury—

M^me^ France Gélinas: I'm fully aware of all of the time—

Hon. Eric Hoskins: You've got a contracted period of time.

M^me^ France Gélinas: I'm interested in money.

Hon. Eric Hoskins: A decision has not been made as of yet. I received recently the report from the committee—

M^me^ France Gélinas: Could you share that with us?

Hon. Eric Hoskins: The committee's report?

M^me^ France Gélinas: Yes.

Hon. Eric Hoskins: I'll ask the ministry to add that to their list to look into.

Obviously, cost is an element of this, but I want to say—and I've said this publicly as well—I attach a significant value to the inconvenience and challenges and hardship of the residents from the north having to travel a long distance to obtain their PET scan, even though they can get it within a two-week waiting period.

M^me^ France Gélinas: When can we expect a decision to be made if a mobile PET scanner will be allowed to come to Sudbury?

Hon. Eric Hoskins: I expect that that decision will be made soon. The committee—it was important because they looked at volumes that are currently being experienced in the area. Those volumes are lower than those areas that would normally have a PET scanner. However, the mobile option is one which hasn't been available as an option until recently. That's a consideration of the committee as well and certainly one of our considerations. I would hope we would be able to make a decision. I would hope the ministry could provide me with that advice soon.

M^me^ France Gélinas: As in before Christmas?

Hon. Eric Hoskins: I think I promised you something else before Christmas. What was that? Just so I remember.

M^me^ France Gélinas: Yes. It was about transgender.

Hon. Eric Hoskins: That's right.

M^me^ France Gélinas: My Christmas list is growing.

Hon. Eric Hoskins: You want two Christmas presents?

M^me^ France Gélinas: Yes.

Hon. Eric Hoskins: I think soon; very soon. I don't want to confine it to a particular period of time. I want to make sure the ministry has the confidence that they can do their due diligence.

1630

Dr. Bob Bell: To let you know, Madame Gélinas, I was speaking to Dr. Denis Roy, probably about a week ago, about this very issue. I understand the importance to the community and recognize the generosity of the Bruno family and the advocacy that they provided in creating a local share contribution for the device as well—

M^me^ France Gélinas: We're ready at our end. We're waiting for a go-ahead from your end.

Hon. Eric Hoskins: We understand that.

M^me^ France Gélinas: Thank you. My next question is: Could you tell me how much money was spent on air transport of Ontarians out of province, or of out-of-province people into Ontario?

Hon. Eric Hoskins: We obviously don't have that.

M^me^ France Gélinas: I know of one who was flown from Timmins to Sudbury, and Ontario paid half and Alberta paid half. I've come to you with two more cases of people who were out of province: one in Quebec and one in Alberta. Do we have a total amount of money that Ontario has spent on air ambulance, either outside of province for Ontarians or inside Ontario for non-Ontarians?

Hon. Eric Hoskins: I don't have that information. I suspect the deputy doesn't. That's something that I can ask the ministry to look into. But I do want to correct you on one point. That one case that you were referring to: Neither Alberta nor Ontario paid in that case; it was paid for by her private insurance.

M^me^ France Gélinas: The lady from Alberta who flew from Timmins to Sudbury was paid for by—

Hon. Eric Hoskins: Yes.

M^me^ France Gélinas: Oh, that's news to me—was paid for by insurance?

Hon. Eric Hoskins: Yes.

M^me^ France Gélinas: Wow. That's news.

A change of topic: 14 LHINs. If I look at the amount of money that is transferred from your ministry to the 14 LHINs, there's a decrease year over year, according to the estimates books. Is this a decrease or is this because I'm not reading this book properly?

Dr. Bob Bell: I can't imagine that there's a decrease, but I'm going to find it.

Hon. Eric Hoskins: I'm certain that you're reading it properly, but I'm hoping that we might have an answer. I don't have it in front of me, given that it's detailed financial information. I'm not sure if the deputy can illuminate us or not.

Dr. Bob Bell: The change from estimates 2014-15 to estimates 2015-16 for the total transfers to LHINs went up by 0.6%. This is on page 142 of the estimates books: estimates 2014-15, $24.36 billion; estimates 2015-16, $24.498 billion.

M^me^ France Gélinas: We can expect the funding for the LHINs to continue to go up?

Dr. Bob Bell: So, $138 million extra funding from the 2014-15 estimates.

M^me^ France Gélinas: Okay. My next question—remember I asked questions about the number of beds

and I gave you different categories? I'm interested in geriatric psychiatry beds that are found in long-term-care homes but also in hospitals. Can I have a number for how many of those beds are in operation in our hospitals and in our long-term-care homes?

Hon. Eric Hoskins: I don't have that information either in front of me or in my brain. I wish my brain was big enough to contain all sorts of numbers, like important ones like these. Unless Minister Damerla has that data, that's something that I'm going to have to reference with my ministry.

M^me^ France Gélinas: But you will be able to give that?

Hon. Eric Hoskins: I'll certainly ask them to look into it, yes.

Dr. Bob Bell: The only thing I can say, Madame Gélinas, is that this is an increasingly important part of our health care provision, as you know. As the associate minister talked about yesterday, the importance of recognizing the behavioural changes that can occur with identification of triggers, the identification of non-pharmaceutical ways of dealing with dysphoria and other symptoms that patients might have—these are becoming important elements. We don't have that number right here, but we certainly can get it.

M^me^ France Gélinas: Okay. We'll all remember that the government had made a commitment to hire 9,000 new nurses. There was a separate pool of funds dedicated to hiring a certain amount of nurses, and that was 9,000. Is there still an envelope specifically allocated for hiring nurses, or is the envelope that was there for the 9,000 done? I'm interested to know if there's a special envelope. If so, I can't find it.

Hon. Eric Hoskins: Okay. The 9,000 nurses initiative was launched in 2008-09, as you mentioned, to support the creation of new nursing positions and roles across the health care system. In 2014—I'm just trying to reference the time frame that you're asking about, from the launch of the initiative. I know that we have an increase—you might have more here, Deputy, but I know that we have seen a 21.6% increase in nurses employed in nursing in this province since 2013.

I don't have the actual benchmark against the 9,000 nurses initiative, but this was an ongoing investment—am I right on this? It's an ongoing envelope, so that to me suggests that it's an ongoing investment.

M^me^ France Gélinas: And the envelope is at $109 million? Is that it?

Hon. Eric Hoskins: I don't have that detailed information at hand. Unless Bob has it, I'll have to reference that back to the ministry for them to look into it.

Dr. Bob Bell: Some of the ongoing programs that are still being funded, as you know, Madame Gélinas, are the new graduate guarantee, where nurses who are offered full-time employment in hospitals have a period of mentorship where they are—

M^me^ France Gélinas: I'm fully aware.

Dr. Bob Bell: —and also the late-career initiatives. As you know, these programs—

The Chair (Ms. Cheri DiNovo): I'm afraid the time is up now. We are going to have to move along to the government side. Mr. Ballard?

Mr. Chris Ballard: Once again, thank you very much to the minister and associate minister for the information and perspective that you've both provided us today. I found it very enlightening, very educational. The both of you, of course, are buried up to your neck in the files that you deal with on a day-to-day basis, but for the rest of us here, we don't often have time to sit and learn as in-depth information as you're providing us today. I particularly enjoyed the background; thank you for that.

Just to comment briefly: I do have a question for the associate minister, but Minister Hoskins, it's always fascinating for me to hear about people's backgrounds. Yours in public health is exceptionally intriguing, and I certainly appreciate the dedication that you bring to that job.

Years ago, I read about "what has saved the most lives in the world," we'll say. I would have assumed that it was the invention of antibiotics—it was the invention of this, it was the invention of that. The person who was writing this article was talking about, "Well, no, it was really early public health that brought sewers and fresh water to medieval towns and cities throughout the world." Maybe that's the foundation of a lot of the work that you do today, that type of advocacy to make things better for all of us, so thank you for that and thank you for that background.

On to Minister Damerla: We've had a fair amount of detail in our discussions thus far. We've heard about many of the great initiatives that our government has undertaken to improve the quality of life for all Ontarians by promoting healthy food choices and ensuring that our young people live healthy, active lives. I know I made those comments yesterday about TV time and computer time instead of getting outside and running around, something that I think all parents are concerned about.

I know we're doing good work right across the province, but I did want to touch a little bit on the communities in northern Ontario, because it takes me back—I mentioned this yesterday—to the many, many years I spent working in very remote fly-in communities across northern Canada, particularly the Northwest Territories, and a little bit in Ontario and the Yukon. The unique conditions in which people of all cultures live—First Nations, aboriginal, Métis and those of other backgrounds as well. It's oftentimes really difficult to understand the challenges that people face, especially those who live in fly-in communities.

I remember the first time I went to a small little community on the northern shores of Great Bear Lake. I walked down to the co-op store, the northern store, and apples were literally $2 apiece. A chicken was $15. It was unbelievable. I thought, "How do you feed yourself here?" It's so difficult.

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If you were a government employee, if you were a teacher or a nurse at the health station or whatever, you were compensated accordingly; you had a northern allowance, in terms of a tax break. But for the local folk, it would be extremely difficult to feed yourself in a way that we would consider healthy, with lots of fresh fruits and vegetables and things like that. The emphasis, of course—and you touched on this yesterday—is a return to more of a traditional lifestyle, in terms of eating foods that could be harvested locally in the north, whether it be caribou or moose, and locally acquired plants and vegetables.

I'll leave my thoughts on that, because I went over them yesterday. I just really wanted to get a sense from you—because as I said, I know about western northern areas more so than northern Ontario.

The question I would have is, are there any special health promotion programs or supports that you offer for those living in northern Ontario?

Hon. Dipika Damerla: That's a really great question, MPP Ballard. It is really interesting that you talk about the access to fruit and vegetables, especially in northern Ontario. The reason I say that is that I spent my early childhood in a tropical country, and I have to say I would have been maybe 10 or 11 years old before I ate meat. Before that it was, all year round, a vegetarian diet with, obviously, a lot of vegetables. So for me, the idea that in a northern country, particularly in northern Ontario, where in the winter access to fruits and vegetables would be really difficult—it's hard for me to imagine how you live for three or four months without access to affordable fruits and vegetables, because it is personally, for me, just out of habit and culture, such a big part of my diet.

I am really very proud and supportive of a program that we have which we call the Northern Fruit and Vegetable Program. What that does is provide, at no cost, fresh fruit and vegetables, in combination with some education around healthy eating and physical activity education, to school kids. The expansion of the Northern Fruit and Vegetable Program in 2014 doubled its reach to more than 36,500 students in 194 schools, including 6,600 aboriginal students, as of January 2015.

The HPD provides, following funding for the three northern public health units as well as the Ontario Fruit and Vegetable Growers' Association, for delivery of the program in their respective regions. I'm just going to go through some numbers, to give some idea of the robustness of the program: Algoma Public Health, $117,000; Sudbury and District Health Unit, $150,000; Porcupine Health Unit, $194,000; Ontario Fruit and Vegetable Growers' Association, $1.1 million. That's another great example of public-private partnership.

I also wanted to pick up on something. I had the opportunity to visit Webequie, another fly-in community in the north. When we were talking to the elders, they talked about something really fascinating. They said that there were programs in place to help those communities do summer farming, so that they could grow their own vegetables through the short summer that they have. I thought that was so powerful. I'm an avid gardener myself. The interest that the Webequie elders showed in continuing that program—it's a federally administered program, and I think it was discontinued. If there are ways to make that work federally, or even for the province at some point later on—but it just gives you an example, more to your point around the idea of eating locally grown food, to the extent that's possible.

The other thing I wanted to talk about, because you picked up on health promotion, which Minister Hoskins spoke about, is that I just wanted to say that public health—you're so right. Vaccinations are probably the single biggest intervention in terms of saving lives. Sometimes we tend to take that part of public health for granted; right? As you said, we have the modern sewage system; we have the vaccinations in place. But it only takes something like SARS to remind us that you have to be ever-vigilant against communicable diseases—because we really don't see those outbreaks as much of many of the diseases that, even 50, 60 years ago would have taken the lives of little kids.

In my own lifetime I've seen chicken pox vaccines—even my daughter, who is only 17, got chicken pox because I think the chicken pox vaccine only came in in 2004 or 2005. I remember clearly her getting chicken pox when she was about two years old, because I took time off from work and that was the time of the George Bush hanging chad episode. In a funny way, because I'm a political junkie, my daughter wasn't well so I was home, and there I was tending to her but also keeping an eye on the whole drama around the hanging chads and the big presidential election.

I remember so vividly my daughter suffering from chicken pox as a baby, and the fact that had she been born a few years later, she probably wouldn't have gotten chicken pox. It just goes to show you that public health is something that we constantly have to be vigilant about.

But I think the bigger change is—what public health has done traditionally is really, really made a big difference in the fact that very few of us now, today, in the western world, in countries like Canada, die of an infectious disease, and I think the next challenge for public health is around chronic disease. The prevention of chronic disease—

The Chair (Ms. Cheri DiNovo): I'm afraid, Associate Minister, you are out of time now.

Hon. Dipika Damerla: Thank you.

The Chair (Ms. Cheri DiNovo): The time for consideration of the 2015-16 estimates of the Ministry of Health and Long-Term Care has expired.

Standing order 66(b) requires that the Chair put, without further amendment or debate, every question necessary to dispose of the estimates.

Are the members ready to vote?

Shall vote 1401, ministry administration program, carry? Carried.

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

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

Shall vote 1405, Ontario Health Insurance Program, carry? Carried.

Shall vote 1406, public health program, carry? Carried.

Shall vote 1411, Local Health Integration Networks and related health service providers, carry? Carried.

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

Shall vote 1413, information systems, carry? Carried.

Shall vote 1414, health promotion, carry? Carried.

Shall vote 1407, health capital program, carry? Carried.

Shall the 2015-16 estimates of the Ministry of Health and Long-Term Care, not including supplementaries, carry? Carried.

Shall I report the 2015-16 estimates of the Ministry of Health and Long-Term Care to the House? Carried.

Thank you.

I believe now we have all-party support to adjourn this committee until November 17 at 9 a.m.

The committee adjourned at 1648.

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