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Mercredi 11 mai 2016

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
Clerk: Eric Rennie

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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON ESTIMATES

COMITÉ PERMANENT DES BUDGETS DES DÉPENSES

Wednesday 11 May 2016

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The committee met at 1546 in room 151.

The Clerk of the Committee (Mr. Eric Rennie): Good afternoon, honourable members. As Clerk of the Committee, it is my duty to call upon you to elect an Acting Chair for today's meeting since neither the Chair nor Vice-Chair is present. I remind members that, pursuant to standing order 117(b), the Chair of the Standing Committee on Estimates shall be a member of a recognized party in opposition to the government.

Are there any nominations for Acting Chair? Madame Gélinas?

M^me^ France Gélinas: I nominate MPP Catherine Fife.

The Clerk of the Committee (Mr. Eric Rennie): Ms. Fife, do you accept the nomination?

Ms. Catherine Fife: Yes.

The Clerk of the Committee (Mr. Eric Rennie): Hearing that Ms. Fife accepts the nomination, are there any further nominations? Seeing none, I declare the nominations closed and Ms. Fife elected Acting Chair of the committee.

Ms. Fife, could you please come to assume the chair?

The Acting Chair (Ms. Catherine Fife): Good afternoon, everyone. Thank you for being here. Before we begin, I would like to remind members that, pursuant to the order of the House dated May 9, 2016, this committee will meet to consider the 2016-17 estimates of the Ministry of Aboriginal Affairs next week, on Tuesday, May 17 and Wednesday, May 18.

The committee will resume consideration of the estimates of the Ministry of Health and Long-Term Care on Tuesday, May 31.

MINISTRY OF HEALTH AND LONG-TERM CARE

The Acting Chair (Ms. Catherine Fife): We are now going to resume consideration of vote 1401 of the estimates of the Ministry of Health and Long-Term Care. There is a total of 13 hours and 59 minutes remaining—but who's counting? If there are any inquiries from yesterday's meeting that the minister or ministry has responses to, perhaps the information can be distributed by the Clerk at the beginning in order to assist the members with any further questions.

Are there any items, Minister, that you have brought with you to share with committee members?

Hon. Eric Hoskins: No. I'm looking forward to the remaining 13 hours and 59 minutes, though.

The Acting Chair (Ms. Catherine Fife): But who's counting?

When the committee adjourned, the official opposition had two minutes left in their round of questions. MPP Walker, the floor is yours.

Mr. Bill Walker: Thank you very much, Madam Chair. You look good in that chair, Madam Chair.

It's a pleasure to be here. Since I only have two minutes—I wanted to get it on the record anyway. I know this is an item near and dear to the minister's heart. I just want to make sure that when we're talking estimates, there's enough estimated money for the Markdale hospital to proceed, and that we will soon have a date where we can actually put a shovel in the ground and move on that.

I am hearing questions in my community. I shared that with you in the House the other day, that the community still is a little bit antsy—"When is it really going to happen?" They just want some more certainty and assurance. Hopefully, we can find something. I know it's working through. I was talking to the CEO of the hospital. He feels things are moving well. But I think if we could find a date, even a tentative date, of starting, that would certainly allay a lot of the concern and distress out in the community. That would be one thing that I would like to bring to the table.

I see the associate minister is here as well. It's nice to be able to give you some profile, but I'm going to do more long-term-care stuff later in our deposition.

Today, I'm going to talk for the most part—when I get rolling in my next little session—about the Assistive Devices Program. That's something that certainly has been front and centre for a lot of people, so I'll be bringing some questions to you there and really asking some of the more challenging things, so I can go back to those constituents and make sure. I know it's a big area for you to look at.

The first one would be that the transportation and communication costs for the Assistive Devices Program were more than four times the 2015-16 estimate. Can you give me some ideas of what the reasons were for those being four times higher than what you had estimated?

Hon. Eric Hoskins: Yes, if you'll bear with me just for a moment, just to gather what we need to be able to—

and my deputy may actually beat me to the—well, maybe he won't beat me.

Just with regard to your specific question, it was the increase over what period of time?

Mr. Bill Walker: Four times more than the 2015-16 estimates.

Hon. Eric Hoskins: For which element in particular?

Mr. Bill Walker: For transportation and communications costs for the Assistive Devices Program.

Hon. Eric Hoskins: Transportation and communications line item?

The Acting Chair (Ms. Catherine Fife): Minister, you'll probably have to get back to that because the two minutes are up.

Hon. Eric Hoskins: I apologize. We will have the answer for you.

The Acting Chair (Ms. Catherine Fife): Now we go to Madame Gélinas for 30 minutes, from the third party.

M^me^ France Gélinas: Thank you, and it's a pleasure to talk to you, Deputy, Associate Minister and Minister. I will go by sections of the health care system except for my first question. My first question is a puzzling one and it has to do with the construction of long-term-care beds in Sioux Lookout. I know that Sioux Lookout is at the front of mind of everybody in this room, and just to make sure, I will recap some of the important dates.

In 1990, a long time ago, 20 EldCap beds open in Sioux Lookout. Then, in 1997, we go through this four-party agreement signed between Canada, Ontario, Sioux Lookout and the NAN that identified the province of Ontario's obligation toward the development of long-term-care plans in that area. In 2000, we agreed that new long-term-care beds were needed. In 2005, your predecessor, Minister of Health George Smitherman, recognized the need for additional beds that were supposed to be constructed during the construction of the new hospital. Meno Ya Win, the new hospital, was developed but the long-term-care beds were not there. In 2010, the facility opened.

Now we are in 2016. Everybody locally has supported the construction of the beds—76 additional beds. A proposal had been submitted to the ministry in 2014 via the LHIN, which gives its support. We are in 2016 and they have heard nothing from the ministry except locally, where the needs are getting higher and higher. The gridlock at Thunder Bay Regional hospital can be linked to the fact that they are caring for a significant amount of people who should be cared for in Sioux Lookout, if this facility were there.

I looked with the best eyes that I could find through the estimates book to see operational funds and capital funds for this worthy project. I have not seen it, so I'm hoping that it's just a mistake, that it's there and I have not seen it. I'm opening it up. I'm not too sure who wants to answer.

Hon. Dipika Damerla: Thank you, MPP Gélinas, for that question and for your advocacy. I just wanted to say that I've been up to Sioux Lookout two times so far. I have visited the Meno Ya Win hospital, which is really lovely. I also visited the Bill George long-term-care facility there as well. I have spoken with the mayor. We've had conversations with the leadership of the First Nations community.

I put all of this context just to say that there has been an ongoing conversation and relationship with all of the stakeholders around the request. I can assure you that work is under way to address the concerns.

As you know we, as a government have committed to coming back with a broader response to the entire Nishnawbe Aski Nation emergency declaration. This piece around how we deal with elder care in Sioux Lookout and, more broadly, in all of northern Ontario is definitely on our radar. What I can commit to is to say that we will be coming up with a response that we think is one that we have worked through with all of the parties as part of the larger response to the NAN situation, which is imminent.

M^me^ France Gélinas: Okay. So the question was that the pre-capital submission provided by Meno Ya Win through the North East LHIN to you has not had any written response. This was 2014. We're now in 2016. When can they expect something in writing coming from the ministry back to them?

Hon. Dipika Damerla: I think what I can say is that we plan a broader response to the entire NAN emergency declaration. We've committed to coming up with a response to that. As part of that response, you will find that there will be a robust response to the particular issue around elder care in the Sioux Lookout area.

M^me^ France Gélinas: That sort of worries me, because the emergency situation that came up in Attawapiskat, although it is within NAN territory—if that hadn't happened, does that mean that their pre-capital submission would have never been answered, too?

Hon. Dipika Damerla: That's a fair question. I would have to say that, as a matter of fact, long before the emergency was declared, work was under way on that particular submission that the Sioux Lookout area had made. In fact, my visit to Sioux Lookout to find out more about the realities on the ground also took place before that.

So I think it would be fair to say that we've been looking at the issue for some time, but it just makes sense to roll all of the response into one comprehensive response, rather than come out piecemeal on this issue. Because the timing works together, we have just decided to roll both of them out at the same time. But I can assure you that work started on that long before any emergencies were declared.

M^me^ France Gélinas: So if I push for a date, when this community has been waiting for two years for a written response, how much longer—are we talking another two years before they hear back? One year?

Hon. Dipika Damerla: Do we have a date that we're looking at?

Dr. Bob Bell: We don't have a firm date, Minister, but we can first of all assure MPP Gélinas that we've had many conversations around that pre-capital submission, and we do anticipate that responses will be shortly forthcoming.

M^me^ France Gélinas: Okay, thank you. That was an aside. I will come back to long-term care, but I wanted to—

Hon. Dipika Damerla: That was just a preview.

M^me^ France Gélinas: A preview. I'll switch into primary care. The first thing I want to deal with is the $85-million increase over three years for recruitment and retention in primary care. I understand it is for family health teams, community health centres and nurse-practitioner-led clinics. Could you tell me when the money will start rolling out, who it will go to, and to which care providers?

Hon. Eric Hoskins: I'll certainly begin on that. Like the compelling argument for long-term care in Sioux Lookout, this is another compelling argument that I began to hear in earnest as soon as I became health minister, and particularly from our nurses, but not solely our nurses or nurse practitioners.

The issue of recruitment and retention, as you know, is an important one. I know you've voiced concern about it yourself, that it affects dietitians, occupational therapists and others who work within that system.

As a result of consultations, we, as you know, passed in the budget the $85-million increase to begin to deal specifically with this challenge that has been identified for us, of recruitment and retention, broadly. I think that if there has been attention on this, particularly media attention, it has sort of gravitated towards nurse practitioners, but it's broader than that—the sorts of health care professionals we're talking about. You're right in identifying—I'm not sure if that's the exhaustive list of the locations, family health teams and community health centres, for example—but that is the area where this disparity is most pronounced and the challenge is most pronounced.

In terms of operationalizing it, I think there were two issues that were important. There was the absolute amount of remuneration received by these categories of health care professionals; but also, there was great opportunity on the pension benefit side as well. With some additional investment, it would allow these categories of health care workers working in these situations to move into a much more favourable pension and pension benefit situation.

So it was really that two-pronged approach: $85 million, a number of health care professionals affected in those areas that you referenced, and starting, in terms of when it begins—

Dr. Bob Bell: Consultations are under way with the Association of Family Health Teams of Ontario and the AOHC right now. The funding is expected to flow shortly for this fiscal, of course. We wanted to provide, based on consultations with CHCs and family health teams, flexibility for allocation that would suit the needs of the individual practices.

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There is a degree of employer flexibility. We're not prescribing rates of increase for each profession. Boards may need to do things differently based on the local labour market circumstances. That said, we're providing a guidance document to show organizations how we arrived at their budget increase, and we expect that most will follow suit. That degree of flexibility within a framework for increase, and certainly the individual teams to determine which professionals need market-value adjustments, are probably what we've heard most in consultation with the field.

Hon. Eric Hoskins: If you'll allow me to ask a question of my own deputy, which is maybe a helpful point of clarification: The funds that we've allocated in the budget will be for this fiscal year?

Dr. Bob Bell: Correct.

Hon. Eric Hoskins: And will it be retroactive to April 1? Is that the idea?

Dr. Bob Bell: The distribution is $22 million this year, $31 million in the 2017-18 estimates and $31.7 million in the 2018-19 estimates. To be absolutely straightforward, I'm not sure if it's retroactive to April 1. It looks to me like it will be fully annualized in 2017-18, Minister.

M^me^ France Gélinas: I was surprised at your first answer, Minister. I've heard about nurse practitioners, dietitians and OTs; you've linked the nurses into that. There are a lot of nurses for $85 million.

Hon. Eric Hoskins: There should have been a second word attached to that. Nurse practitioners are nurses, but I was implying—and I think I quickly got to the nurse practitioner part of that, so I apologize if there was any confusion in what I said.

M^me^ France Gélinas: I just wanted to be clear.

Deputy, you said that you're talking to the Association of Family Health Teams and the association of community health centres. What about NPAO?

Dr. Bob Bell: Yes, and NPAO as well.

M^me^ France Gélinas: NPAO as well? Okay.

Dr. Bob Bell: Correct.

Hon. Eric Hoskins: In fact, I have to say that they've been instrumental in helping us devise what ultimately our proposed solution has been.

M^me^ France Gélinas: Okay. You piqued my interest when you said that it may be other than CHCs, FHTs and nurse practitioner-led clinics. Who else did you have in mind?

Dr. Bob Bell: Nurse practitioner-led clinics would be the additional ones to the associations that I mentioned.

M^me^ France Gélinas: So those are the three professions and those are the three—

Dr. Bob Bell: Models.

M^me^ France Gélinas: —models of care that are—

Dr. Bob Bell: Correct—the interprofessional models of care that we're currently supporting.

M^me^ France Gélinas: Talking about those three models of care: I'm pretty up to date with what's happening with family health teams and how they can grow and how physicians can join those. It's not as clear to me what happens to communities that want community health centres or nurse practitioner-led clinics. What is

the rate of growth to this? What is the process for having more of those?

Hon. Eric Hoskins: I'll maybe gently kick it off. Certainly, with reference to our community health centres—I don't know if there are any active plans in terms of increasing the number of nurse practitioner-led clinics. I believe that there are not, currently.

Dr. Bob Bell: Or CHCs.

Hon. Eric Hoskins: Or CHCs as well. My deputy has just helped make my answer shorter than it otherwise might have been.

Dr. Bob Bell: However, Minister, if I may?

Hon. Eric Hoskins: Go ahead.

Dr. Bob Bell: One of the things we want to do is maximize the opportunity with family health teams to utilize the infrastructure that's being created. We have a number of situations where satellite family health teams are either starting up or in the planning phase.

The other expectation is that the interprofessional resources within family health teams, within CHCs, are beginning to be shared with other primary care providers in the community to ensure that access is based on need rather than the model of remuneration that your primary care physician is engaged in. It needs to be a more evidence-based approach to who needs interdisciplinary care resources.

The other thing we talked earlier today, Mrs. Gélinas, at SCOPA was about Minister Hoskins's discussion document. One of the anticipations in that document, as you know, is that LHINs will become responsible for planning and performance measurement in primary care. Our expectation is that LHINs will become much more active in recruitment, in deciding what model of private care is appropriate for communities that need more primary care, and in evaluating the access to interdisciplinary resources that citizens achieve from any model of care of primary care practitioner. That's one of the elements of the proposal.

M^me^ France Gélinas: We see, within the budget, that there is a 5% increase for community care. Does any of this 5% increase in the budget flow to community health centres or nurse-practitioner-led clinics, aside from the $85 million you've identified for recruitment and retention?

Dr. Bob Bell: No.

M^me^ France Gélinas: Zero? None? Okay.

You've talked about satellites, and you're absolutely right that there are opportunities. What happens to communities where a satellite of a community health centre will make more sense than a satellite of a family health team—if they have a family health team, they get the satellite; if they have a community health centre, they don't?

Dr. Bob Bell: We're looking at these different models now.

Mr. Walker raised earlier the situation of the CHC in Markdale, where we think there may be opportunities to add providers by varying some of the regulations around the approach. We're certainly looking at these new models.

M^me^ France Gélinas: Yes, but if there is no money in the budget to increase their budget, how do they do this? Volunteer physicians are hard to come by.

Dr. Bob Bell: For example, what we're looking at is primary care providers who are fee-for-service currently—the potential for actually moving them into a CHC model.

M^me^ France Gélinas: Really?

Dr. Bob Bell: The potential exists.

M^me^ France Gélinas: Wow. That's great news. I didn't know that. Thank you.

My next question has to do with Healthy Smiles—still in primary care, kind of. Again, I tried my best to look at those numbers, and they're not always easy to follow, so help me: How much funding was allocated to CINOT, Children in Need of Treatment, in 2015-16, and how much was actually spent? At the same time, how much was allocated to Healthy Smiles in 2015-16, and how much was actually spent? How come I cannot find this on my own?

Hon. Eric Hoskins: We pride ourselves for actually having a good understanding of the intricacies of the ministry, but I think both of us are going to have to—Bob, if you've got it first, go ahead.

Dr. Bob Bell: France, in 2013-14, CINOT accounted for 37,493 patients; in 2014-15, 35,792; and in 2015-16, 36,244. These are patients who are in the CINOT classification. The number seems to be fairly consistent within the integrated program as it was before when it was a specialized program.

M^me^ France Gélinas: No. I was asking: how much funding?

Hon. Eric Hoskins: Money.

Dr. Bob Bell: How much money? The answer to that—

Hon. Eric Hoskins: Yes, I don't have that in front of me. It might be that somebody—

Dr. Bob Bell: Do we have the funding equivalent for the treatment of those patients?

Ms. Roselle Martino: For CINOT, it was $10 million, and for Healthy Smiles, it was $30 million.

Hon. Eric Hoskins: Sorry, again?

Ms. Roselle Martino: CINOT, $10 million; Healthy Smiles, $30 million.

Hon. Eric Hoskins: For which year?

Ms. Roselle Martino: For 2015-16.

Hon. Eric Hoskins: For 2015-16.

The Acting Chair (Ms. Catherine Fife): Excuse me, could you identify yourself for the record, because you're speaking into the microphone?

Dr. Bob Bell: Why don't you sit over here, Roselle?

The Acting Chair (Ms. Catherine Fife): Can you please introduce yourself to the committee?

Ms. Roselle Martino: I'm Roselle Martino. I'm the ADM of the population and public health division.

The Acting Chair (Ms. Catherine Fife): Did you want to formally enter your comments into the record, or do you want to—

Hon. Eric Hoskins: I think she was just giving us a piece of oral information that we could utilize.

For the 2015-16 fiscal year, the CINOT program, the funding allocation for that, or the expenditure, is $10 million, and for Healthy Smiles it's $30 million for the same fiscal.

M^me^ France Gélinas: And how much of that was spent?

Ms. Roselle Martino: All was spent.

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M^me^ France Gélinas: The full amount?

Ms. Roselle Martino: Yes.

M^me^ France Gélinas: So you had budgeted $10 million and you came in exactly at $10 million?

Ms. Roselle Martino: There was no money left over.

M^me^ France Gélinas: Okay. I know, Deputy, you went through it quickly, but could you tell me how many children received services under Healthy Smiles in 2015-16—the number of children?

Hon. Eric Hoskins: I can do that. In 2015-16 for Healthy Smiles, 41,832—is that correct?—active clients transitioned over to the newly integrated model of Healthy Smiles.

I think the deputy already referenced that in that same fiscal year of 2015-16, 36,244 were treated under CINOT.

M^me^ France Gélinas: So, transitioned over—

Interjections.

Hon. Eric Hoskins: Right. Okay, I'm reminded—the deputy just pointed out—that for the Healthy Smiles number, the 41,832, that is as of January 2016, so it's not quite the full fiscal year.

M^me^ France Gélinas: Okay. You used the words "transitioned over." Does "transitioned over" mean that they were kids receiving dental care, or kids eligible for dental care? What does that mean, anyway?

Hon. Eric Hoskins: These are individuals who transitioned into the new program and received care.

M^me^ France Gélinas: Why are we using the word "transitioned"? Does it mean something that I'm not getting?

Hon. Eric Hoskins: These were individuals who were enrolled under the previous programs and were grandfathered—I hate using the term, if there's another term other than "grandfathered"—into the new program, so they were eligible prior to the combining of the six different programs. They maintained their eligibility throughout transitioning into the new program in that fashion. That was the number of transitioned individuals who received care under the new program.

M^me^ France Gélinas: Gotcha. Thank you for the clarification.

I know that Accerta is now the one who will be handling the claims for Healthy Smiles. Is their contract public?

Hon. Eric Hoskins: It is not currently a public document.

M^me^ France Gélinas: Okay. Without sharing any secrets that I'm not supposed to know, how are they being paid? How do we pay them for their work? Is it a set amount? Is it so much per client? How does it work?

Interjections.

Hon. Eric Hoskins: It would probably be easier if she just speaks directly. It will save us all time.

Ms. Roselle Martino: Sorry, it's all these binders here, and my chair is funny.

Accerta is being paid under a transfer payment agreement. The majority of their payment is from the claims base. You will recall—Madame Gélinas, you've asked this question before—where we did not take any money away from health units, and we let them keep that money, when we went into a third-party administrator. The only money that we took away was what we were paying fee-for-service dentists, and that is what Accerta is using to pay claims. So they're on a claims basis; that's how they get paid.

M^me^ France Gélinas: Okay. We have a really tough time, in all of Sudbury and the northeast, to get kids in to dentists through the new Healthy Smiles Ontario program. I will tell you what happened: All of the dentists in Sudbury say that they're full and they're not taking new clients. Then they ask you, "What is your dental plan?" If your dental plan is one that pays well, you get a call back and all of a sudden, there is an opening in that full caseload. If your dental plan happens to be Healthy Smiles, they are all full and they don't want to see you.

Is Sudbury the only one having this fun time?

Ms. Roselle Martino: Minister, do you want me to take this one?

Hon. Eric Hoskins: Sure, go ahead.

Ms. Roselle Martino: I'm not fully sighted on every aspect of the province. What I can say is that there is an increasing number of participating dentists in the program. The exact number in your riding, Madame Gélinas—I don't know that to heart. I can get that information.

But I will say there's an increasing number, and one of the reasons is the third-party administrator, because dentists were saying that they were getting burdened with the administrative aspects of dealing with certain clientele. So we've taken that away from the dentists. We've also instituted—the new program has a navigation program, which is really important. Health units are actually navigating and working with these clients to ensure they get to their appointments, to give them transportation money if they need it and to remind them that they need to go to these appointments. All of those things are making the service much easier for dentists to provide. So I know there's an increasing number of dentists participating in the program.

M^me^ France Gélinas: None of them in the northeast, and that's not what I hear. What I hear is that the program doesn't pay enough. They get paid 40 cents on the dollar. Therefore, that's why they do the "We're all full," unless you have a better dental plan.

Hon. Eric Hoskins: I'm optimistic that with the streamlining of the six programs into one, as we just

heard—it's certainly better for the patient. Access is a critical issue, of course, but patients and families only have to apply one time to a single program. It's the same eligibility. We made changes that public health asked for to accommodate what they felt were important elements that needed to be retained.

It was at my initiative that I created a discussion table with representatives of the Ontario Dental Association to discuss a number of issues that are important to this, including Healthy Smiles, and find ways we can make it work better. There's no doubt that it's taking the administrative burden away from dentists. I think that's part of the explanation of why there's a greater interest of dentists taking on this responsibility.

We're looking at a variety of issues, but certainly Healthy Smiles, from the provider's perspective, is one that we're looking at through this table I referenced.

Dr. Bob Bell: Minister, I can just give you a current add-on performance of the program.

Madame Gélinas, a total of 312,000 patients enrolled, and over the last two months, from January 1 to February 29, 2016, over 60,000 claims have been submitted, suggesting that probably up to a fifth of patients had obtained service within that time period of two months. So we are getting uptake. We don't have the data for Sudbury, but we are getting uptake across the province, with 20% of kids being seen in that two-month time period.

M^me^ France Gélinas: Okay. I know that I talked about the 5% increase to the community health sector. Can I have a breakdown as to how this money was spent, as in where did it go—not necessarily geographically but what programs received money within that 5% increase to the community health sector?

The Acting Chair (Ms. Catherine Fife): Just so you know, we have two more minutes left in this cycle.

Dr. Bob Bell: The categories—while we're finding the absolute proportions, the categories are right here.

Hon. Eric Hoskins: I'll see if I can get this in in under two minutes. The total for 2015-16 was $264,200,000; $113 million went into LHIN investments to support provincial and local priorities, it says. I can get into more details—

M^me^ France Gélinas: Yes, do, because I already know that. That was in the press release. I want to know where it went.

Hon. Eric Hoskins: Expanding service capacity and reducing ALC pressures through such initiatives as Health Links, assess and restore, convalescent care beds and community paramedicine programs.

M^me^ France Gélinas: Can I have the breakdown for each of those? As to the $113 million, how much went to those five different programs?

Hon. Eric Hoskins: I can certainly speak to my ministry about that. The PSW wage enhancement—I just want to get this in if I can—$77.8 million; comprehensive mental health and addictions strategy, $37.5 million; other ministry initiatives adding up to $35 million, including palliative care supports, a Youthdale centre day treatment and 10-bed unit; supports to exceptional care clients and other mental health and addictions services; access to care initiatives to improve access to mental health care and reduce wait-times at the four specialized psychiatric hospitals; and aboriginal engagement initiatives, totalling $264 million.

You've got time to spare.

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M^me^ France Gélinas: You can read pretty fast. If you don't mind, if you could drill down as to how much money each of those got—

Hon. Eric Hoskins: Within?

M^me^ France Gélinas: Within. That would be very helpful. Thank you.

The Acting Chair (Ms. Catherine Fife): Okay, thank you. We will now move to 30 minutes to the minister for a response.

Mr. Han Dong: Chair, could we take five minutes' recess?

The Acting Chair (Ms. Catherine Fife): The minister now has 30 minutes to respond, and then we go to the government side. You have 30 minutes.

Hon. Eric Hoskins: Do you want me to start while we're waiting for her to come back? I would be happy to talk for several minutes about the exceptional work that the associate minister is doing. And as the door mysteriously opens behind me—

Hon. Dipika Damerla: Perfect timing.

Hon. Eric Hoskins: There you go.

Hon. Dipika Damerla: Madam Chair, members of the committee and members of the public: Thank you again for the opportunity now to make some formal remarks. It is an honour for me to appear here along with Minister Eric Hoskins before this committee as Associate Minister of Health and Long-Term Care to speak about my responsibilities for long-term care and wellness. Today provides me with an opportunity to update the people of Ontario on the significant progress we are making.

Let me begin with long-term-care homes, because I know that's of special interest to both MPP Walker and MPP Gélinas. As outlined for this committee last fall, one of the priorities of my mandate is to strengthen accountability and transparency, especially of our long-term-care homes inspection system. Our government has made the safety, security and peace of mind of our seniors, their families and their caregivers our foremost priority.

That is why I would like speak first to the quality of care provided in long-term-care homes across the province. In Ontario today, there are approximately 78,000 residents in more than 630 long-term-care-homes. Our government is committed to ensuring that resident rights, safety, and quality of care are preserved by inspecting complaints, concerns, and critical incidents that may arise. We have transformed the inspection process to achieve a more accountable, consistent and transparent compliance inspection program that focuses on risk issues and resident care outcomes.

You may recall that in June of 2013 the government announced that every long-term-care home would receive a comprehensive annual inspection by the end of 2014, and every year thereafter. I am pleased to report that for the second consecutive year, we have met our commitment: Every home in the province has undergone a comprehensive inspection. That includes interviews with the residents and their families as well as staff; direct observations of how care is being delivered; and a thorough review of records such as individual care plans and progress reports. These inspections are centred on the needs of the residents and follow a consistent, objective and research-based approach, and, most importantly, these inspections are unannounced.

As MPP Gélinas may recall—you brought forward to me a complaint from one of the nursing homes in your riding. As it happened, that particular nursing home, a few weeks later, ended up having one of those unannounced inspections. So I think the system in this sense is working.

The inspectors ensure that all homes are in compliance with the Long-Term Care Homes Act, 2007, its regulations and associated agreements for long-term-care homes, and, where necessary, apply enforcement measures. Most importantly, and in keeping with our government's commitment to Ontarians, the process is transparent. Copies of inspection reports detailing any non-compliance findings are publicly posted in long-term-care homes and on the ministry's website. When it comes to transparency, in particular in terms of disclosing information on long-term-care homes, I do believe that Ontario is a leader. Our government is committed to ensuring that those Ontarians who need long-term care receive the best care possible as residents of our long-term-care homes.

The ministry, in conjunction with local health integration networks, continues to monitor the need for long-term-care-home beds throughout the province on an ongoing basis. Together, the ministry and the LHINs are currently examining future needs for long-term-care-home capacity and are planning accordingly.

I see that MPP Walker is taking notes. I expect a question on that at some point.

Our government's commitment to quality is also reflected in our funding commitments for long-term-care homes. That funding has doubled to $4.05 billion in 2016-17 from $2.1 billion in 2003-04.

As part of the 2016 budget, the ministry is increasing its investment in resident care needs by 2% a year over the next three years.

The 2016 budget also included an investment of an additional $10 million annually in Behavioural Supports Ontario, or BSO. We all understand that as people age they are more prone to dementia and other complex behavioural and neurological conditions. It's something that the health care system grapples with every day. BSO is designed to help people with challenging and complex behaviours wherever they live, whether it be at home, in a long-term-care home or somewhere else.

Our government has enhanced, and continues to enhance, the amount and quality of care and services provided to residents of long-term-care homes.

Another priority of my mandate is to further strengthen our quality framework for the long-term-care sector, and I am particularly excited about the role of the Centres for Learning, Research and Innovation—CLRI—in long-term care in advancing this work. The CLRIs have been developed to enhance the quality of care in the long-term-care sector through education, research, innovation, evidence-based service delivery and design, and knowledge transfer. Ontario is the first Canadian jurisdiction to introduce centres focused on this critical mandate.

Three long-term-care-home Centres of Learning, Research and Innovation to enhance the quality of seniors' care in the province have been established: the Village at University Gates, in Waterloo; the Baycrest Centre for Geriatric Care and the Jewish Home for the Aged, in Toronto; and the Bruyère Research Institute, Saint-Louis Residence, in Ottawa.

I just wanted to say, MPP Walker and MPP Gélinas, if you haven't visited any of these, please do because it really is something that we, as Ontarians, can be really proud of. I think we're the only jurisdiction in Canada to have these Centres for Learning, Research and Innovation, which are established where the long-term-care home is. This is not academia, doing research outside of the practical work environment. It's very powerful. I've visited all three, and I would certainly urge you—because I know how passionate both of you are as critics of this file—to visit them.

With such an ambitious mandate, I am excited about the possibility of these centres to bring new insight in how to best care for seniors.

Although our focus remains on long-term care and ensuring that those Ontarians who need long-term care receive the best care possible as residents of our long-term-care homes, at the same time we also recognize that most Ontarians would prefer to remain at home for as long as possible. That is why our government continues to focus on investments in home and community care to ensure they can get the care they need as close to home as possible.

Using an integrated approach to capacity planning allows for the consideration of multiple options for care delivery to respond to the needs of a changing population and an assessment of associated impacts across the health care system.

Long-term-care-home redevelopment: Our government recognizes that Ontarians aren't going to be able to live at home forever. A time does come when some Ontarians need to move to a long-term-care home. That is why we have put a real emphasis on ensuring our long-term-care homes are exactly that: homes.

Ontarians deserve to live in a comfortable, safe and inviting environment. I am pleased to be able to tell you that our government has already made significant gains on this front over the last decade. We have created more

than 10,000 new long-term-care-home beds and redeveloped approximately 13,500 older long-term-care-home beds, but we recognize that more needs to be done to speed up the pace of redevelopment.

Due to the acuity of long-term-care-home residents, it is more important than ever that we invest in the continued safety and quality of care for residents by helping to bring all long-term-care homes in the province up to the most current design standards.

Chair, would you be able to give me some idea of how much time I have left?

The Acting Chair (Ms. Catherine Fife): You have 22 minutes.

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Hon. Dipika Damerla: Thank you.

In October of 2014, I announced that our government was moving forward with a multi-faceted strategy to accelerate the modernization of long-term-care homes in this province. This is a critical step in our government's goal of redeveloping more than 30,000 long-term-care home beds. We have indeed made a great deal of progress on the commitments found in our strategy.

Our first commitment to the people of Ontario was to create a dedicated project office to support the program within the ministry, and that is now done. There is now a single point of contact for long-term-care home operators, which is an immense help, as you can imagine, for long-term-care home providers in working with the ministry through a complex redevelopment process.

Our second commitment was to enhance the construction funding subsidy to better support the costs of redeveloping long-term-care homes. Again, we have done that. We increased the construction funding subsidy by up to $4.73 per day per bed, and posted the new policy to our website in 2015. We have supported increases to preferred accommodation premiums and extended the maximum licence term from 25 years to 30 years for homes that redevelop to meet current design standards. We established a committee to review individual requests for variances from the existing design standards, so now when operators want to ask about design flexibility, we are in a position to consider their proposals.

Finally, our government has been actively encouraging the renewal of long-term-care homes. In fact, I have already announced the first of several redevelopment projects that our government has approved under the new strategy. Let me just give you a few examples of the announcements that I have made recently.

One was in Stouffville, Bloomington Cove Care Community, where more than 30 resident spaces will be redeveloped. I have had the pleasure of visiting Bloomington a few times, and what's remarkable about this particular long-term-care home is that 100% of the residents there have dementia. That just tells us how specialized the care in Bloomington Cove is and their expertise in that area, but also it gives us pause to recognize the acuity and the kind of residents that are increasingly living in our long-term-care homes. That speaks to, again, our increased investments of $10 million a year, every year, for BSO.

Another example of a redevelopment that I recently announced was Faith Manor nursing home in Brampton, where they are redeveloping 120 resident spaces. Another one, closer to where MPP Gélinas is from, was in Iroquois Falls, South Centennial Manor, where more than 69 spaces will be redeveloped.

All of these redevelopments are intended to put the needs of residents first, to make the functioning of the home as efficient as possible while also creating a desirable workspace for the people who work there. Residents will benefit from an environment that is comfortable, aesthetically pleasing and as home-like as possible. There will be additional space for specialized programs like rehab and physiotherapy. Rooms will be more spacious and there will be a maximum of two residents per bedroom. Renovated homes will have better wheelchair access in bedrooms, bathrooms, showers and doorways, more air-conditioned areas, and accessible dining areas that provide a home-like atmosphere. Wherever possible, there will be more private work spaces for staff.

I am very excited to be announcing these projects because I know these enhancements are going to make a significant difference in the lives of residents. More of these announcements are on the way as more projects are approved under the strategy and we continue to evaluate the applications that have been submitted for consideration.

I do want to share a really positive experience that I had in Iroquois Falls. I've always said that it's really important for us to redevelop and modernize the long-term-care homes, but at the end of the day, a home becomes a home because of the people who live there and because of the front-line care providers who work there. I just wanted to share that when I was in Iroquois Falls, I was shown around the facility and they showed me a room which acts like a hospice space. What was remarkable was that that room had been designed, fundraised and built with the leadership of the staff over there. They took it upon themselves to say, "We need this special space." They researched it; they designed it. The community and the front-line workers and their families actually came and painted the room and built the furniture. You had to be there to really see the dedication and the investment that the staff has made over and above what might be expected of them. I think it's that spirit that really makes our long-term-care homes among the best, I believe, in the world and certainly makes it a privilege for me to serve as the associate minister responsible for long-term care.

I'd like to now spend some time on the other area that the Premier has asked me to focus on, and that is health and wellness initiatives.

I'd like to begin by speaking to some of the progress we are making with respect to health and wellness over the last year. We made several strides in our efforts to improve the health and wellness of Ontarians.

Smoke-free Ontario: Our government has been committed for many years now to achieve the lowest

smoking rate in Canada. Since 2005, Ontario has become an international leader in tobacco control because of our Smoke-Free Ontario Act. This year marks the 10th anniversary of our Smoke-Free Ontario Strategy.

Ontario is taking steps to protect Ontarians from the harmful effects of tobacco use, help more people quit smoking and ensure that young people don't get addicted. As I outlined to you last fall, we took an important step forward on this issue last year with the passing of the Making Healthier Choices Act, 2015. That act is playing an important role in empowering Ontarians to make the decisions that help them lead healthier lives and moving us even closer to a truly smoke-free Ontario.

As of January 1, 2016, the act:

—increased the maximum fines for youth-related sales offences;

—prohibited the sale of tobacco products containing flavouring, including menthol-flavoured tobacco;

—improved enforcement to address indoor use of tobacco in water-pipe bars and restaurants, expanded the seizure authority of SFOA inspectors, and updated the rights of entry for inspectors;

—clarified that it is prohibited to offer promotional items for sale with the purchase of tobacco; and

—expanded the government's power to make certain regulations under the Smoke-Free Ontario Act.

That work built on new regulations that took effect in January 2015 that make it more difficult for young people to purchase tobacco by prohibiting tobacco sales on post-secondary education campuses. The new regulations also prohibit smoking on bar and restaurant outdoor patios as well as on playgrounds, publicly owned sporting areas, spectator areas adjacent to sporting areas, and the 20 metres surrounding these areas.

Our government continues to take active steps to protect young people from the health risks and impacts of smoking.

We are also moving forward with regulating electronic cigarettes. As of January 1 of this year, we banned the sale and supply of electronic cigarettes to minors. We are also proposing changes that would regulate the use, sale, display and promotion of electronic cigarettes.

We know that children are more vulnerable to the harmful effects of second-hand smoke exposure, and studies show that young people are less likely to become regular smokers when living in areas with strong tobacco control regulations as compared to areas where regulations are weaker. That is why we are taking these necessary steps to better protect our children and all Ontarians.

It is also why, as part of the 2016 budget, our government increased the tobacco tax rate by $3 per carton of 200 cigarettes. We will use $5 million of the increased revenues from the tax in 2016-17 to enhance priority populations' access to smoking cessation services, no matter where they live in the province. This includes First Nations.

We are continuing to work on a new, innovative cessation strategy focusing on creating an inclusive and coordinated cessation system that meets the needs of Ontario's tobacco users and their families, and the communities in which they live.

Our efforts to reduce smoking rates in Ontario are working. The smoking rate in Ontario fell from 24.5% in 2000 to 17.4% in 2014. That represents 408,000 fewer smokers, at a time when the population of Ontario continues to grow.

Our Smoke-Free Ontario Strategy continues to be an important piece of our Patients First: Action Plan for Health Care, and it continues to support the key objectives of the action plan through our efforts to provide the education, information and transparency Ontarians need to make the right decisions about their health. We believe that prevention is a critical piece of the puzzle in helping Ontarians stay healthy, and we are committed to ensuring that Ontarians, especially the youngest amongst us, have the information they need to make better choices about staying healthy.

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But I also recognize that government is only one partner among many important stakeholders when it comes to ensuring that Ontario has among the lowest smoking rates in Canada and in the world. That is why, on the 10th anniversary of the smoke-free legislation, we are looking forward—and I hope all of you will join us. On May 31, we will be recognizing volunteers or anybody who has dedicated their lives or has done exceptional service to make Ontario smoke-free. We are calling them the Heather Crowe awards. That will be on May 31.

We did a province-wide blitz to get nominations. I really am pleased to say that we got a robust number of nominations from across the province. We're in the process now of going through and selecting the final winners. We really believe that this is a wonderful way, in the name of Heather Crowe, for all of us to be able to celebrate 10 years of smoke-free Ontario legislation and the giant strides that we have all made together—government and all of our key stakeholders. I'm really looking forward to celebrating this, and I look forward to your presence there as well.

In addition to smoking, another priority area for us is healthy eating. I'm just going to talk a little bit about our Healthy Kids Strategy. Another important piece of the Patients First Action Plan is our government's commitment to encourage physical activity and healthy eating through the Healthy Kids Strategy. Back in March 2013, the Healthy Kids Panel submitted its report, No Time to Wait: The Healthy Kids Strategy, to the Minister of Health and Long-Term Care. In response to the panel's recommendations, we launched Ontario's Healthy Kids Strategy, which takes a whole-child approach to healthy child/youth growth and development.

The Healthy Kids Strategy is focused on three pillars. The first pillar is ensuring children get a healthy start by supporting health before and during pregnancy, and during the early years, to build the foundation for a healthy childhood and beyond.

The second pillar is focused on healthy food, including initiatives to promote healthy eating, achieving healthy weights and healthy childhood development.

The final pillar speaks to having healthy, active communities and building healthy environments for kids in their communities.

The Healthy Kids Strategy is creating new health promotion and prevention programs and building on the ones we already have, to protect the health of our children and set the stage for improved longer-term health outcomes. A big part of our strategy is the Healthy Kids Community Challenge, which is designed to promote children's health by focusing on physical activity and healthy eating.

We know that healthy behaviours bring many benefits to our children, their families and communities. Just 60 minutes of daily physical activity helps children and youth to develop healthy bones, muscles and joints, healthy hearts and lungs, and better coordination. We know that children who are active, eat healthy foods and get enough sleep have higher self-esteem and lower levels of depression, anxiety and emotional distress. In short, they enjoy better overall mental health—and, may I add, what's good for kids is good for adults too.

Studies also show that children who lead healthier lives do better academically and socially in school. They're more self-confident and enjoy more successful social interactions and integration.

To help our children succeed, we felt it was really important to engage entire communities, along with families and individuals, to bring about behavioural change at the local level. That's what the Healthy Kids Community Challenge will help us to achieve. The Healthy Kids Community Challenge is mobilizing communities, families, schools, local businesses, health, recreation and other organizations to help our young people lead healthier lives. We asked communities to implement programs and initiatives in their communities that will inspire the kind of active, balanced lifestyle that our children and young people need. We did this because we felt that it was critical for our communities to play a role in this effort, because our children's future is a shared responsibility. More than 45 communities were selected to participate through the application process.

Late last summer and into last fall, we launched new programs as part of the Healthy Kids Community Challenge in communities across the province, from Windsor to Ottawa and from Kenora to Niagara. All of them were memorable, but there was one in Sudbury that was particularly memorable. The MPP for Sudbury, MPP Thibeault, may remember when the mayor of Sudbury took to—I think it was a giant slide that he went down. It would make for a really good photograph. It's interesting how adults sometimes forget to have fun. I think all of us took a turn on the playground, and that was a lot of fun.

These successful communities represent almost 40% of Ontario's population and include 36 municipalities and six aboriginal health access centres. I think that's really important for me to emphasize. I was really, really pleased at the response from the First Nations communities as to how important the Healthy Kids Community Challenge was for them and how well they have embraced it. Again, Sudbury was among the places where the aboriginal community came together, along with other stakeholders, to partner.

Through the Healthy Kids Community Challenge and other measures we have introduced, our government has acted upon over half of the panel's recommendations. We enhanced the capacity of health practitioners via tools to support pre-conception and prenatal health and to help practitioners to address healthy weights with children, youth and their caregivers during pediatric visits.

We doubled the funding and reach of the Northern Fruit and Vegetable Program and the Healthy Eating and Active Living program for urban aboriginal and First Nations communities. Our Healthy Menu Choices Act, 2015, which received royal assent in May of last year, will make it easier for families to make informed and healthier food choices.

The Acting Chair (Ms. Catherine Fife): Associate Minister, you have four minutes left.

Hon. Dipika Damerla: Oh, thank you. That's very helpful, Chair.

Our government wants every parent, grandparent and family to know that we are committed to the health of our young people, and we are working hard with all of our dedicated municipal, provincial and other partners to help them live healthy as children and reach a healthy adulthood. It is all part of our commitment through the Patients First Action Plan to put people and patients first.

I do want to take a minute to also acknowledge our parliamentary assistants, who are over here, MPP Indira Naidoo-Harris and MPP John Fraser, who have been invaluable in their support to both Minister Hoskins and myself. I also want to give a shout-out to MPP Sophie Kiwala, who played a huge role, particularly during—I think that you led the committee on smoke-free Ontario when we were pushing the legislation through.

Thank you so much, actually, to all of you for all of the work that you do. I just wanted to make sure that we acknowledged that.

In conclusion, Madam Chair, I'm honoured to serve the people of Ontario in my role as associate minister with responsibilities for both long-term care and health promotion. I've always said they're almost like two bookends of the care system: On the one hand, we're talking health promotion; on the other hand, we're talking long-term care. It has been a real privilege.

I think that if you were to compare our notes from last year to this year, you would see—and I hope it will bear out in the questioning that will follow—that we've made significant progress over the last one year. Minister Hoskins, if I can borrow a phrase, sometimes we do a lot of things under the hood that don't always show up right away in terms of announcements, but I just have to say that we have been working in both long-term care as well as in health promotion; we've been doing a lot of things that are sort of behind the scenes and don't always make the headlines but I can honestly say will have a powerful and positive impact in the near term and, more importantly, in the medium term. I'm really privileged that

we've had the opportunity, along with Deputy Minister Bob Bell, to make these changes. I look forward to sharing more detail on that.

I don't know, Madam Chair, how I'm doing with time.

The Acting Chair (Ms. Catherine Fife): You have two minutes left.

Hon. Dipika Damerla: Okay. I don't think that I did enough justice to the issue of menu labelling, so I'm going to speak, in the last two minutes, on menu labelling.

Those of you who heard me speak before probably know that this is a topic that's near and dear to my heart. I am certainly looking forward to the day that we can have calories next the latte or the Cinnabon or the muffin.

I have to say I was in Chicago over Christmas. It was really nice to be able to walk into a Starbucks—I guess it changes the lens, sometimes, with which you order something, because you now not only look at the flavour, but you start to look at the size, and you think, "Maybe I should go with the small, because the calories are fewer."

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Context is everything. I used to be among those who used to be a regular Cinnabon eater. That used to be one of my weaknesses until I learned, to my horror, that one of those little vanilla types can pack 800 calories. If you go to the really fancy ones, some of them are at 2,000 calories. So it's been really useful, and I think it will be very useful for all of us to have that kind of information. I just wanted to—

Interjection.

Hon. Dipika Damerla: What's that?

Mr. Glenn Thibeault: I said that I'm still craving one right now.

Hon. Dipika Damerla: You're still craving one.

The last thing that I just wanted to say was that this morning, I was at a conference on the issue of healthy eating, and the question was, "Can we eat healthy in today's world?" I see the Chair is about to cut me off. If you will indulge me, Chair, there was an American speaker who presented there, and she said, "We often look to Canada to see what we ought to be doing when it comes to health promotion." That was a real shout-out, because we often forget that we can also—

The Acting Chair (Ms. Catherine Fife): Thank you, Minister. Thank you for ruining the Cinnabon for all of us.

So I was mistaken. The next round of questioning goes to the PC Party. MPP Walker, you have 20 minutes.

Mr. Bill Walker: Associate Minister, I kind of thought that you would have given a bit of a shout-out to France and I for raising your profile at every opportunity to make sure that your cabinet members know how important your ministry is. I'll allow you that next time you talk. Maybe you could get us on the record with all of your colleagues.

Hon. Dipika Damerla: I will, indeed. I had to leave something for next time.

Mr. Bill Walker: You've talked about a lot of stuff in there. I'm going to go back to my notes in a minute, but you did bring up a couple of different items in regard to long-term care. So I'm just going to do a quick one now, and we'll get back into this in much more detail at a later date.

You said you wanted "to strengthen accountability and transparency." It was a quote that you used at the very start of your outlook. Yet, I've asked you numerous times for the plan to build those 30,000 beds and you haven't given me that plan. You haven't shared anything with where you were going to build the beds and the timeline, so it's a little tough to say "accountability and transparency" when you won't give me any of that information. I'm going to ask, once again, that you provide me with that as soon as possible so that we actually know that you do.

You contradicted yourself a little bit because at one point, and again I paraphrase, you said that the LHINs are exploring future needs, and yet we already know there's a waiting list of 24,000 people. You're exploring, but you say you have a plan. I'm not certain how you can be exploring and have a plan at the same time. If you didn't have a plan, where did you find that 30,000 or 35,000 number that you committed to over two different elections? So there are a lot of questions that I have in regard to that whole specific area.

You invited Ms. Gélinas and myself to tour facilities that you referenced. Perhaps an idea, so that we can actually truly collaborate, would be for you to extend an invitation when you're touring, so that we can go and be effective and efficient and actually work as a full government, as opposed to not getting invited. I'm going to put on the record here that some things happened in my riding that I didn't even get the courtesy of the minister letting me know about—not the health minister; I won't say that. We can all raise the civility of this place by doing those things and not just using hollow words of collaboration and working together, something as simple as inviting us when you're having some of you are announcements. Let us know ahead of time. We might not be so critical if you actually let us in on what the supposed plan is. I think there are some huge opportunities.

You talked about redeveloping and that you want real emphasis—you said 10,000 new beds and 13,500 redeveloped beds. Again, I struggle with—I'm not trying to be critical, but you haven't accomplished 30% of your initiative of the 30,000 beds, if I use the 13,500—slightly over—and yet you seem to be quite proud of that. I still don't see the plan, even though you know that there are 24,000 people on a waiting list, and that's going to double in six years. The Long Term Care Association has told you that. They have done their stats. They are experts in their field. Yet, we still, I don't believe, have a credible plan that you're going to actually get there, or a time frame to let those seniors—the baby boom demographic, as we all know—the time for studies is behind us. That's coming at us. We need to have credible, realistic and practical numbers that we can bank on.

You talked a lot about Bloomington, the 30 beds, and that's great. I applaud you for 30 beds, and it sounds very

specialized, but again, there are a lot of people out there who don't have a bed. There are a lot of people and families who are struggling because they don't have the ability to even know when they're going to get a bed. That adds stress for the whole family, which adds definitely to our health care system. This is one of the ones—ad nauseam, you probably think, I ask you this and challenge you on this, but it truly is the reality of what I face every day. I'm certain that France, Ms. Gélinas, faces that, and I'm sure all of the members of the House do because it's not just specific to my riding or rural Ontario. This is across the board.

You said, "more on the way as part of the strategy," but I get confused because, again, you say you have a strategy and yet the LHINs are out studying and investigating. You're kind of talking both ways, and you confuse me when you say that. Either just tell me you don't have a strategy, you don't have a plan and you really don't have the numbers to do those 30,000 beds, and then we can maybe start from ground zero, or share with me that plan so I can try to help collaborate and get you further on that plan and expedite it.

Where is that plan? I don't know why this is so hard, when I ask for something that, to me, is pretty basic, that you won't share with us, and yet you use continually the words "accountability and transparency." I'm going to have a much more thorough and detailed questioning of those.

You talked a little bit about health and wellness, so I just want to get on the record that I believe through that whole process we asked you many times—not just myself but a number of members of the Legislature—why you're not doing anything with contraband. We all know that that is a big issue. If you walk into any of the ridings where contraband is available, that's where the kids are getting their cigarettes; that is where those youth are starting to smoke.

I have two boys, 18 and 21. Sadly, they're both smokers. It drives me absolutely crazy. It's the one thing I didn't want them to do in their life, and they do. A lot of where they access that, and where they tell me they access it, is from contraband cigarettes. You can buy a whole bag of them for eight bucks, and you're doing nothing tangible that I can see to even try to restrict that. There are more and more smoke shops starting up. They're prevalent. There's a lot of money going to a lot of negative things, and yet that is the one that's going to impact our system the most.

I'm a recreation director. I believe in the whole "stay healthy and eat the right foods," but that is going to cost our system and cost our youth and our society more than anything I believe that you can be doing.

Diabetic strips are one thing that you talked about. Certainly in my backyard I have two First Nations, and the incidence of diabetes is quite a bit higher in the First Nations population. And yet you cut, a couple of budgets ago, diabetic strips.

I'm, again, a believer in the preventative. If people aren't testing, if they actually don't have those and they're making a choice—"Do I have the money to buy those strips," and they don't—then they end up in the emergency room, because they're not testing nearly as frequently. It baffles me that you have a preventative opportunity and yet you cut that funding. I still haven't received a rationalization of what the benefit of that was. If you had numbers again to prove to me that that was going to be beneficial—the people in my riding continually ask me why we can't get funding for those. They're telling me, "I don't test regularly because I can't afford to do it. I can't afford those strips."

I believe the diabetes association's issue or concern is that they call for public coverage to increase access to offloading devices, such as total contact casts, custom braces and orthoses to help treat diabetic foot ulcers and reduce the risk of amputation in people with the disease.

Their other issue is that they recommend that the Ontario government conduct a public awareness campaign to ensure people with diabetes are aware of OHIP-insured regular eye exams every 12 months for adults with diabetes aged 20 to 64. Again, that's a very proactive, preventative thing that you could be spending on, and it takes me to healthiness.

In my case, I'm trying to remember whether you actually froze the funding or you decreased the funding, but in a sparsely populated rural area, the key is actually education, awareness and promotion. I trust that what you may tell me, because I think I've already heard it before, is that some needed more money because they weren't keeping up and they weren't able to do as much. Well, by cutting in an area like ours where we don't have other resources around us, if you cut that out in Bruce–Grey–Owen Sound, there isn't another agency. You don't just walk down the street or take the subway to get to resource B, C, D, E and F. We have one resource. My public health officials have come to me and said, "Bill, I really don't understand this." They're doing great work. You have to educate. You have to raise the awareness, and they don't the ability the same as you do in an urban centre, because they don't have access to all the things you have.

Again, it's a case of, for all of these types of things, I think there are lots of opportunity for more preventative, more proactive opportunity, and yet when I look at these—and I am critical of you—you're cutting out the preventative, the proactive that can have a huge ripple impact from a positive perspective. You demoralize, frankly, the people who are out on those front lines when they see those things happen and more money going into—in this case, I'm not saying there isn't need in the urban centres to have more, but not at the cost of areas like ours where we don't have enough resources to begin with.

You speak a fair bit about First Nations in most of your policy. I have two in my backyard, but you are still cutting and impacting them in a negative way with each one of these cuts. I struggle with that.

1700

I'm going to talk again, and I'm going to go back—also, I just want to make sure. I didn't know if you were

staying. I wanted to comment on some of the things that you have, and I'm going to go to some of what we've prepared as well.

So I'm going to go back again, if I could, to the minister. First and foremost is back to that Markdale hospital. I know that you're very supportive. I know personally that you and I have chatted. I don't think I gave you the opportunity to actually give an answer: Is there any opportunity to provide at least a date, coming forward, that we can go to the community and tell them that this is a reality and that it's going to happen? It doesn't have to be September 2, although if you would say that date, I'd be quite pleased to take that back tonight. But if you could give us—is it six months, is it eight months? I get that there's a process and it's being followed, but I think we also should be able to say, with all credibility, "Within the next eight months, we are going to be starting construction."

Hon. Eric Hoskins: If I can start with that—and you personally do know how committed I am to the Markdale hospital.

Mr. Bill Walker: I do.

Hon. Eric Hoskins: I think I made a bold statement a couple of years back when I said that the community would have an answer as to their request for a new hospital—their very legitimate request—before the leaves fell off the trees. I think there was a shockwave through the ministry when they saw me saying that publicly and it being reported in the news as such. But we met and actually beat that target. You understand, obviously, the process that needs to be gone through.

I do know that the ministry met with the CEO of the hospital one or two weeks ago. I raised this shortly after our conversation earlier this week with the ministry, or perhaps it was Friday or Thursday of last week—I think it was earlier this week—to have a better understanding of where we were in the process and if the necessary decisions and approvals were imminent.

I feel confident that this is a process that we're expediting as much as we can do, but making sure that we're doing it in a responsible fashion. I think that the next step on our side—is it not?—is that we've received a proposal, and I believe it's the functional proposal.

Interjection.

Hon. Eric Hoskins: I'm confident that we'll have greater clarity to the community very, very soon.

I believe that you appreciate as well the necessity of going through the various steps, as the community did when I went there to make the announcement within the time frame that I had committed to. I'm certainly doing everything I can within my responsibility for the province as minister, and in a responsible way, to see this project through.

I know that the community is so invested in this, and the leadership of the hospital and the board as well are working very closely with us.

Mr. Bill Walker: Yes, and I do want to echo that I do appreciate it. I have been watching from the sidelines and keeping in contact, so I do know there's a process I certainly appreciate.

It's just that I have the luxury of being able to talk to you in the House and get that, but the community doesn't always hear that from you, right? So it's just give me some firm—because they are getting pushback. The corporation went out a couple of weeks ago and had to get a recommitment from a municipality for funding, and they got a lot of pushback on the questioning and why the costs went so high.

Their mindset is that every day we wait, that cost keeps going up, and what is that impact to the taxpayer and what is the impact to them as the fundraising arm of it? So as I say, if we can just get something concrete—and, again, I appreciate the whole process, but even kind of a tentative, "Here's where we're planning. We're looking at the summer of, the July of." As I say, September 2 would be a much better date, in my mind, and I think we'd both be happy.

But I do appreciate everything that's going on. I just wanted to take the opportunity here to put it back on the record and gently thank you for what you're doing, and to just make sure that we can give that assurance to the community.

Hon. Eric Hoskins: I do believe that the ministry, together with the proponents in the community, are very close to the approval of the functional stage, which is a very critical element of being able to move forward with the capital investment. I'm confident that both parties are working very well together. My folks, particularly in the capital branch, know that probably more than just about any other hospital, I always talk about Markdale and ask for updates.

Dr. Bob Bell: Just to give you a sense, Mr. Walker, about the level of knowledge, we know, for example, that one of the discussions going on is the depth of the basement and elements related to those sorts of concrete concerns about what is going to be built on the site.

Mr. Bill Walker: Sure. Thank you.

The other one—and I spoke to the deputy minister as we came in about the South East Grey Community Health Centre. That's one that I think is actually a great thing. I've passed on the information. They've doubled their output. They have, I believe, the highest patient satisfaction record in the province. They have the lowest cost per patient to do that. They've doubled their output, but their funding has actually remained pretty stagnant. They've gone through the LHIN process. I don't believe they've been able to move forward to get any additional funding. I'm glad to hear that you're looking at some creative ways to be able to accommodate that. Again, I just wanted to put that on the record. That's one that I think is a good reflection of what we can do when we are creative, when we're innovative and when we actually serve the community to the best of our ability. Thank you very much.

Hon. Eric Hoskins: I hope you got the answer and clarity that you were looking for when you discussed it with the deputy.

Mr. Bill Walker: Well, we got most of it. It wasn't black and white, but we're getting there. Thank you very much.

I'm going to go back to my first line. I think I only had two minutes, and I don't know if I really ever asked a question. The transportation/communication costs for the Assistive Devices Program were more than four times the 2015-16 estimate. I just wanted to get a sense of what that reason was, what change didn't allow you to accomplish that goal you had set.

Hon. Eric Hoskins: In fact, that figure that's provided in the interim actuals for 2015-16, the figure of $685,500, is quite consistent with previous years, and certainly the year previous. It doesn't so much represent an increase in expenditure as it does—the line item provided and the amount provided in the specific line for transportation and communication, I think historically as well, has been underrepresented. It has been under the actual that is spent. That particular line of transportation and communication is comprised of telephone costs, postage, printing and travel; as well, there's a component of "other."

That would be the answer I would give you. It doesn't represent so much an increase as it does—it's consistent with previous years. What it does point out, and it's not necessarily unique to this line, is that the estimate provided in the budget didn't accurately reflect what the likely expenditure might be over the course of the year.

Mr. Bill Walker: Minister, that's where I get confused. If you spend that much time on creating a budget and estimates, why wouldn't that be reflected, to be more accurate? Even a footnote saying, "This wasn't right for the last three years, but here it is"—because it certainly leads a guy like me to say, "Well, it's four times over." What's changed?

It's kind of fundamental to the way I think. You do a budget—I've done tons of budgets—and you set that as a guiding document. It doesn't have to be exact, but you typically want to know that you're pretty accurate, and you're only going to change it if there's a massive anomaly.

Hon. Eric Hoskins: I think in that year, in fact, there were anomalies. We're talking about a line item—in fact, all of the categories represent about 1% of the total budget of the ADP, and that one even less so; it's about one eighth of 1%. It's a very small number to begin with. I believe I'm correct that we made some changes to the ADP, because we're constantly reviewing not only our relationship with the providers but also the various elements of the eligibility for the products that are offered through ADP.

There was a significant investment in postage and printing that was required to be able to inform—I think we've got about 5,000; it's certainly in the thousands in terms of those both on the assessor side, but also those who provide the ADP equipment itself. We faced something similar as well under the services line, where there was an additional investment.

It's sometimes difficult. Because of the nature of the review process, it may be difficult to predict in that line item that there may be a surge in that, which is unique and the result of an anomaly or something specific to that—

The Acting Chair (Ms. Catherine Fife): Sorry, Minister. Mr. Walker, you still have two minutes left.

Mr. Bill Walker: Thank you. The other one is very near and dear to my heart. Port Elgin native and London resident Jeff Preston, who has been in the media, has had extraneous challenges with his wheelchair. It's supposed to be replaced in five years. He's now into his seventh or eighth year; I can't remember which one now. It took him nine months just to get an assessment.

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This is a young man who has fought every challenge in his life. He's an amazing young man. He's actually a professor at London Fanshawe College. I just provide some context of that one: Every day, he wakes up wondering, "Is this going to be the day I lose my independence because that chair breaks?" It's unacceptable that someone has to go through that on a day-to-day basis—numerous cases. You cut $20 million from the Assistive Devices Program. My challenge is that there are actually a lot of people out there—there are going to be more and more challenges with technology. Many of the actual pieces of equipment are becoming more expensive. I find it interesting that we would cut $20 million from the Assistive Devices Program when we know that need is out there, particularly when there are real-life situations like Jeff's. Waiting that long for a wheelchair is just unacceptable.

The Acting Chair (Ms. Catherine Fife): You have one minute.

Hon. Eric Hoskins: In fact, we didn't decrease the funding for ADP. The increase to the base for that fiscal year that we referenced is a $14.3-million base adjustment increase. That's probably all I have time for, but I'm happy to continue. So we've got a bit of time?

The Acting Chair (Ms. Catherine Fife): There's 30 seconds.

Hon. Eric Hoskins: Okay. On the wheelchair, I was trying to understand if it's the assessment side or the repair side, because we have about 5,000 individuals or entities around the province who participate in the assessment of individuals for eligibility—5,000 of them, and they are health care professionals in the entities that they work for. Then there's the other side, which perhaps is what you're referring to, which is the maintenance and repair—

Mr. Bill Walker: No, it was just the assessment: nine months just to get it assessed.

The Acting Chair (Ms. Catherine Fife): Okay. That question will have to wait for the next round. The NDP, Madame Gélinas: You have 20 minutes.

M^me^ France Gélinas: Thank you. Although I'm very interested in this question, I will switch topics. My first one was on primary care, so this next one will be on long-term care. I was interested in your statement that the amount of care has been increasing yearly. Do you keep track of the average number of hours of hands-on care that the ministry funds in our long-term care homes?

Hon. Dipika Damerla: Thank you, Madame Gélinas, for the question. I'd like to begin by—yes, it was remiss

of me to not have formally acknowledged the great service that both of the critics to the health care portfolio bring and the vast knowledge and, frankly, your advocacy as well. So thank you so much.

Mr. Bill Walker: My pleasure.

M^me^ France Gélinas: You're welcome.

Hon. Dipika Damerla: One of the things that you may have noticed is that long-term care is definitely one of the items that, in budget after budget, consistently we have increased funding. As you know, we measure the acuity of every resident who comes into a long-term-care home. Then you aggregate all of that and you get something called a case mix index, the CMI, of a long-term-care home. I know you're very familiar with that. That is the basis on which we fund a long-term-care home. Typically, if your acuity or your case mix index is going up, you can expect to see an increase in funding. Should it be stable or if the acuity decreases—which is, of course, I would admit, very, very rare—then that funding would follow that way.

I think we do, in that sense, track because we measure the acuity of each individual resident who comes in and then we periodically reassess them. I believe the act requires an assessment every six months of the resident. That is really taken into consideration as we fund homes.

I'm going to ask the deputy minister: Do we actually collect the issue around hours of care?

Dr. Bob Bell: Yes, we do. If we look at the average hours of direct care per resident, day paid hours, and we look at the years 2008 to 2014, we can see that the direct hours of care per resident day have increased from 3.16 hours in 2008 to 3.48 hours in 2014. The average funding in the NPC and PSS envelope that pays for care: Funding per CMI unit has also gone up over the last few years, since I've been looking at it, which is another way of measuring direct care per unit of acuity. So we do measure it; it is increasing.

Hon. Dipika Damerla: If I may just add something, and that is, sometimes the devil is in the details. For instance, I learned recently that when we measure hours of care, the hours of care that are provided by somebody like a physician isn't counted. So if you were to add that—so, you know, I wouldn't get too caught up in that exact number because a lot of it also depends on—for example, we are not capturing the hours of direct care that a physician might come and spend at the bedside of a long-term-care resident, just as an example.

Dr. Bob Bell: The other thing to say just in terms of funding increases over that same period of the 2012 to 2016-17 estimates—a 9% increase in the budget for those budget lines, so over 2% per year.

M^me^ France Gélinas: Deputy, I'm interested—we go from 3.16 hours of hands-on care in 2008 to 3.48 hours of hands-on care in 2014. The way you do your calculation: You take the NPC, the PSS and make that the equivalent in hours, and then divide it by the number of residents. Is this as simple as that, or is there other—

Dr. Bob Bell: As you know, we actually do an accounting for the number of worked hours of the various classes of health professionals that provide care as well. If we look at NPC, we would have data on RN staff, registered practical nursing staff and personal support worker staff. We get estimates based on the number of worked hours for all of those categories, divided by the number of residents, to get those figures for each one of those care categories.

M^me^ France Gélinas: I'm glad you say this, because then I will ask: Could you share that with me? What is the number of hours of RNs, RPNs and PSWs that make up the 3.48 hours for 2014? I wouldn't mind, if you have it for 2015, if you could also share that with me. I would ask that you share that with me in a way that is either per home, or, if I could not have this per home, then I would ask by category of home, where home for the aged, charitable homes, private long-term-care, private nursing home and not-for-profit nursing homes would be separated into four categories.

Hon. Dipika Damerla: If I can just answer on that: Thank you for that. What I will do is, I will see if we can get back to you on that.

M^me^ France Gélinas: Okay. From what you've said, Deputy, we have the work hours from the RNs, the RPNs, and the PSWs for nursing and personal care. What do you do with the PSS envelope before you go on to your 3.48 hours of care?

Dr. Bob Bell: We also look at the total worked hours for PSS staff, recreational therapists, physiotherapists, occupational therapists, etc., and divide that by the number of resident days that are being provided by those paid hours of work.

M^me^ France Gélinas: Then I would ask for those numbers that you have for recreational therapists, physiotherapists, occupational therapists and others that make up the PSS envelope. If you can give that to me attached to the dollars, you will get a star. If you don't, I will figure it out by myself, but I would much prefer to have it with the dollar amount. Again, if it can be separated by home for the aged, etc.

Hon. Dipika Damerla: Once again, we'll take that back and see what we can do with that.

M^me^ France Gélinas: Okay. That's much, much appreciated.

The former Minister of Health had said that she would make the staffing information by long-term-care home public on the Ministry of Health website. This has not happened, and it has not been talked about very much. It's not something that costs an awful lot, but it's something that is of value to families who are trying to decide which home they would like to put their loved ones in. Has there been any more thought given to that promise that was made by the previous Minister of Health?

Hon. Dipika Damerla: I'll have to go back and check on that, but I did want to take the opportunity to tell you that, as a ministry, we do believe that transparency is key. I believe that very shortly we are relaunching a revamped website, particularly around long-term care, that will give a lot more information, particularly around inspection

information, which is another very critical piece of information as families look to which home they would like to put their loved ones in. We believe it's a win-win because it's transparent. It would actually give you information on the last inspection, how many written notifications there were and how many compliance orders there were by home, for example, which allows families to get that information that is really critical.

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I also think that going transparent with that helps the entire sector to look at what their peers are doing and brings everybody's standards up. So we're really, really excited about that. We look forward to launching that website and we'll definitely let you know once we do that.

M^me^ France Gélinas: Sounds good.

We know that the wait-list for placement into long-term care stands at about 24,000 people. Can I have the list as to how many people are on the wait-list per CCAC?

Hon. Dipika Damerla: Actually, Madame Gélinas, that information should be available online, because each of the CCACs does report their wait times. We can take that back as well and see what we can do.

M^me^ France Gélinas: They report their wait time, not their wait-list.

Hon. Dipika Damerla: Again, we'll take that back and see what we can get back to you, but relevant information on wait times would be available by CCAC.

M^me^ France Gélinas: Okay. Here again, an idea of the number of beds—because they keep changing as to how many beds are in charitable, not-for-profit, long-term care etc., the four types of long-term-care homes—so that I know how many beds are left in each of those four categories. And when you do this, what do you do with municipal homes for the aged that have sub-contracted the running of the homes to a for-profit agency? How do you report that?

Hon. Dipika Damerla: My understanding is that whether a home is considered in the for-profit sector or a municipally run home really depends on who the main operator is. I know what you're talking about is who they subcontract to, but the classification is based on whether it's a municipal home.

For example, municipal homes don't need licences, as you probably know. You need licences to run a long-term-care home if you're a for-profit provider, but if you happen to be a municipal home you don't need licences, just as an example. So we would categorize it mainly dependent on who the key operator is and not the subcontractor.

M^me^ France Gélinas: Okay. Do you know how many homes for the aged are being subcontracted to for-profit companies? Do you know how many beds fall within that?

Hon. Dipika Damerla: I would have to go back and check. What I can tell you is that all three categories—the for-profit, the not-for-profit and the municipal homes—are critical. I think having all three operating in the long-term-care sector is really, really useful because each brings certain strengths to the sector, and together, I believe that makes the sector more robust. So we welcome the participation of all.

M^me^ France Gélinas: You've talked about bed redevelopment. I would be curious to see where the beds are that are presently being redeveloped, if you could share that with me. How many are we talking about that are presently being redeveloped?

I'm also curious about the 75 nurse practitioners that were announced. Are we at 75 right now in long-term care?

Hon. Dipika Damerla: All along, it was a phased implementation. We announced 75 in all, but we also announced that phase 1 would be 30, and then we would roll out another 30 and then finally get to 75. My understanding is that work is well under way for the first 30. A number of them have been hired; a number of them are in the process of being hired. Simultaneously, we are again starting to think about the second tranche as well. So phase 1 is being implemented—the first 30 nurse practitioners.

M^me^ France Gélinas: I would be interested to find out how much money has been spent on nurse practitioners in long-term care out of whatever number has been hired and are in positions right now.

Hon. Dipika Damerla: Again, we'll go back and check and see what we can get back to you on that information.

M^me^ France Gélinas: So the idea is that—I thought the 30 should have been in place by March of this year and the next 30 should have started on April 1 of this year. Am I wrong?

Hon. Dipika Damerla: I can give you an update. I can confirm that 11 positions have been hired and 19 are completing the recruitment process. The 11 hired are serving in 14 long-term-care homes. As you can imagine, it's a highly qualified position that homes are recruiting for, and sometimes you want to make sure that you get the fit right. I think the process is well under way, and we'll go back and see what we can get back to you in terms of how much of the funding has been drawn down. We'll go back and see what we can do in terms of getting back to you.

M^me^ France Gélinas: Is this a set amount that every long-term-care home gets to hire a nurse practitioner? Does every one of them get $100,000, or do some get more, some get less?

Hon. Dipika Damerla: I believe we have set aside a budget for each nurse practitioner—it's per position.

M^me^ France Gélinas: And how much is the budget per position?

Hon. Dipika Damerla: I believe it's $114,000 and change.

M^me^ France Gélinas: Okay.

Hon. Dipika Damerla: And in addition to that we also give some overhead in terms of administering, HR and things like that.

M^me^ France Gélinas: What percentage do you give for overhead?

Hon. Dipika Damerla: We'll get back to you on that.

M^me^ France Gélinas: Okay. So of the 30 positions, 11 have been hired. Does the ministry specify the kind of hiring arrangements: As in do they become employees of long-term-care homes or are they self-contracted NPs who offer services to—

Hon. Dipika Damerla: Deputy, do you want to answer?

Dr. Bob Bell: Yes, thanks. I understand that we provide the money to the LHINs and it's up to the LHINs and the long-term-care home to determine what the best hiring practice is for the individual situation. I would imagine most of them become employees of the long-term-care homes.

M^me^ France Gélinas: I would beg to differ. Right now, part of the reason why you don't have that much of a pickup for this is that the nurse practitioners are being offered contracts without benefits: "No, you're not an employee; you're a self-employed contractor that offers services to long-term care," without benefits, without vacations.

Dr. Bob Bell: I'm told that even if they are independent contractors—as you know there are some advantages to being independent contractors that professionals want to pursue, but even if that's the case, there is money provided for benefits.

M^me^ France Gélinas: Okay. Well, I would turn that around and say that the nurse practitioners would like to be employees with benefits, pension plans and vacations, and that's not what's being offered to them—just to put it out there.

I am all for having nurse practitioners in long-term-care homes. I think it could be a good fit. I wish they would roll out quicker. Certainly the amount of money, at $114,000, is way more than any primary care could ever hope to offer at this point. The lack of uptake seems to be that they don't have a choice to become employees; they have to become self-employed.

Hon. Dipika Damerla: If I can just say that I have every confidence that we will be rolling this out. I think with tranche one there were some lessons learned as well that will help us with tranche two and tranche three. That was one of the reasons we did the phased implementation. I'm very hopeful. We've already hired 11, and the others will fall into place.

M^me^ France Gélinas: If you could get back to me on this, I would appreciate it.

Hon. Dipika Damerla: We'll see what we can get back to you on. Thank you.

M^me^ France Gélinas: I want to talk a little bit about the food per diem. Right now, it stands at $8.03 as far as—

The Acting Chair (Ms. Catherine Fife): Madame Gélinas, you have two minutes.

M^me^ France Gélinas: Okay. Is it going up this year?

Hon. Dipika Damerla: It is going up, yes.

M^me^ France Gélinas: To?

Hon. Dipika Damerla: I believe it's—what's the percentage increase? Perhaps someone will give me the figure. I think it's going up by 30 cents?

Interjections.

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M^me^ France Gélinas: As soon as you find that out, if you could let me know. I'm also interested in the "other accommodation" line. How much is "other accommodation" going up by this year?

Hon. Dipika Damerla: Overall, I can tell you that nursing care is going up by 2%. We'll see what we can do about getting back to you with a breakdown. We'll see what we can get back to you with on that.

M^me^ France Gélinas: Okay.

Dr. Bob Bell: Madame Gélinas, our expectation is—as you know, food CPI this year is higher than CPI in general. We anticipate that food CPI would be the methodology for calculating the raw food allocation,

M^me^ France Gélinas: Once this is confirmed, could you let the researcher know? And the same thing with the "other accommodation" line: How much is this line going to go up this year?

Hon. Dipika Damerla: We'll see what we can get back to you with.

M^me^ France Gélinas: Thank you. I take it I'm done?

The Acting Chair (Ms. Catherine Fife): Yes. Okay, thank you. We now have 20 minutes for the government side. Mr. Thibeault.

Mr. Glenn Thibeault: Thank you, Chair. Just to confirm, you said I have 20 minutes, not 30, right? Twenty minutes?

The Acting Chair (Ms. Catherine Fife): You have 20.

Mr. Glenn Thibeault: Thank you, Chair.

First off, I want to thank the ministers and the deputy minister for being here today and sitting here with us and answering these questions.

I also think it's important right now to put on the record that I would like to publicly thank both ministers and the deputy minister for your staff, who do great work for all of us as MPPs. Usually when we're calling, we're calling with some sort of crisis or some sort of emergency. Your staff do a great job in helping us address that, and do a great job representing you and the ministry and the government. I just thought it would be important, while a lot of them are in this room, to say thank you for the work they do.

I also think it's important to put on the record—and I think my colleague from Nickel Belt, Madame Gélinas, would agree with me—that not all dentists in Sudbury are grumpy, Scrooge-type people, and that many of them do provide services in the Healthy Smiles program.

Interjection.

Mr. Glenn Thibeault: Yes, 79. I know Dr. Roch St-Aubin has talked with us. He is the ODA rep from the Sudbury area. The ODA is working with the ministry on trying to address some of the concerns they have. I think no system is perfect, and it's great that there is always that open dialogue there.

I believe, if I got my numbers correctly, approximately 312,000 kids are using that program, and with the way it has now been streamlined, it's 70,000 more kids. When we made the announcement in Sudbury, we had a family

there, a woman, a single mom, who was talking about how her five kids have accessed that program, so it's great. I just thought it paramount that I mention that, because my neighbour is a dentist, and the next time he has a very sharp, pointy thing in my mouth, I wanted to make sure that we acknowledged that dentists are actually involved in this program.

Many of you watched as I limped in here. I'm just recently coming off some reconstructive knee surgery. It was a massive undertaking. I don't want to get into all of the details, but it was a high tibial osteotomy, for those who are doctors, who want to know what that is. What's great about my quick experience in the health care system was that I went into the hospital and I showed my health card—I didn't have to show my credit card—and I think that's something that every MPP in this room would be extremely proud of.

We have great doctors in Sudbury. Dr. Kevan Saidi was my surgeon. He's a rock star. I'm thrilled with the recovery. I think it's important, if we look at all the great doctors—we have Kevan Saidi, Dr. Tubin and Dr. Robinson, just in the ortho piece. Dr. Hourtovenko is a cardiologist in Sudbury. Let's recognize that they're part of this new group that has come to Sudbury, that's part of Ontario.

What are the stats? Since 2003, the number of doctors in Ontario has increased by over 5,600. That's an over 26% increase in doctors that we've seen in Ontario. I think it's paramount for us to recognize what this government has been doing to invest in making sure that we have doctors in communities like Sudbury and throughout northern Ontario, northeastern Ontario and right across our great province.

Besides my own health issues that I'm talking about here—not that we're here to listen to all of my health issues—my daughters were born in the health system here—well, no, hang on. My oldest daughter was born in British Columbia, in North Vancouver, but we moved back—born and raised in Sudbury—two weeks after she was born.

I come from a very unique situation. I was born in 1969. My mother was 44 and my dad was 56. My mother, in her wanting to get out to see my first daughter born in British Columbia, had an aneurysm on her aorta. While getting her tests done, something happened and she had a stroke. So all of a sudden, we realized that it was important for us to move back home because we wanted my daughter to be able to learn and experience the extended family and all of those other things.

My father was 56 years old, as I mentioned. His friends used to joke that he was the only guy they knew who was collecting Old Age Security and a baby bonus at the same time, because he was 65 and I was nine. For most of my life, I had my parents at many of my events, at my sporting events, because they were retired.

As young man—I was nine, 10—or a young boy at that time and then as a teenager, going through that whole process of now having older siblings and seeing uncles and aunts having to go through the process of what are they going to do; are they going to stay in their home; are they going to go into long-term care? I had that unique perspective.

If we go back to when my mother had her aneurysm and then the stroke, my dad was, if I recall his age, 93 when this happened. If you understand 93-year-olds, if you ever have that opportunity of having a father who is 93, they're pretty stubborn. One of the things that we were very fortunate to have in Sudbury was the CCAC offering services to come in and provide and help my mother. My father said, "No, no, no, no. That's my job."

It's a different perspective of trying to see how we can ensure that our parents recognize that there is help there when you need it, if you ask for it. We've set up systems within our government to ensure that our older population can actually get the supports that they need when they need them.

I lost my mum in 2009. She was at Health Sciences North on the fourth floor in the palliative section of the hospital. The nurses there were phenomenal. I'm very honoured to be able to put this on the record today: Heath Sciences North's nurses were phenomenal, and we thank them for that.

Again, talking about the number of nurses that we have brought forward as a government: Since 2003, we've seen that number rise by 13.9%, from 49.5% in 2003 to 63.4% in 2015. That is a significant number.

The irony of the fourth floor for me is that my dad passed away last year at 101. I'm sad, because you lose your father, but 101, that's a pretty good run; right? How many of us would like to be able to say that we could make it to 101?

But he lived in his house with my sisters up until five months before he passed away. Remember the commercial with the Hair Club—not that I'm talking about my own hair—"Not only am I the president, I'm also a member"? It was the same thing for me.

Not only was I an MPP, having to deal with long-term care and some of the issues that revolve around that—we all agree that there are things going on with long-term care. Not only was I living that as an MPP, but I was also living it as a son, sitting down with the individuals there, saying, "I would like my father to get this type of care. How do we make this happen?"

It was a difficult process to go through, as any family would have to go through, but knowing that there were services there and that we didn't have to panic—if a place opened up where we wanted to send my father, we could send him there. That place, unfortunately, didn't go up and my dad passed, as I said, on the fourth floor at HSN with these quality nurses, again, who just did great things.

I know that I've painted a big story here—I've talked a lot and I've done a long story—but I thought it was important to share that, because I think when we go around this room and we think about our roles as politicians, we all have a role to play and we're all talking about our policies, but we're all trying to do the right thing. I think we need to get past sometimes all of the partisanship that

happens and look at this as sons, daughters, brothers and sisters.

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I have—oh my God, I'm going to get in trouble, but some of my sisters are going to be 65 soon, and they're starting to think about their long-term care. They're all 29, but yes, some of them might be 65 soon.

I guess, Ministers, if I can put the question: Our population is aging, and we've got more and more Ontarians who may need to rely on the care provided by one of our hospitals or the specialized treatment of a long-term-care facility. We all expect that our parents and our grandparents will get that highest level of care possible at the right time and in the right place. Minister, could you provide this committee with an update on the plan to ensure that our health system is able to meet the needs of our parents and of our grandparents, both now and in the future?

Dr. Bob Bell: On the question of capacity planning, would it be reasonable for ADM Patrick Dicerni to answer that question?

Mr. Glenn Thibeault: Sure. That'd be fine. Thank you.

Dr. Bob Bell: Wonderful. Is that okay, Minister? Would you like to start off?

Hon. Dipika Damerla: Yes. Thank you, MPP Thibeault, for putting a personal context, because health care, at the end of the day, is about touching people's lives. I think we get that, the minister gets that, the Premier gets that, and that's why we keep saying "the right care at the right time in the right place." It's got to be appropriate care, whether it's acute care or whether it's long-term care.

One of the bigger issues facing us obviously, particularly with an aging demographic, is: Do we have the right configuration of care, the right balance between primary care, acute care and long-term care today and 10 years or 20 years from now? I'm really pleased to tell the committee here that, indeed, work is taking place on that. I can honestly say that Ontario is now a leader when it comes to—we are doing a system-wide capacity plan.

I want to directly address MPP Walker on this issue. The number of long-term-care beds, X, depends on how much I'm investing in community care, right? It depends on how much we're investing in assisted living. They don't function independently. So when you say "capacity planning," I think we can all agree that we have to plan the entire system. You can't plan one in isolation, because each impacts the other.

On the other hand, we don't want to get paralyzed by the idea that, "Oh, we have to plan the whole system and boil the whole ocean in one go," because that's not possible either. What we have done at the Ministry of Health under the guidance of both Minister Hoskins, myself and Deputy Bell is that we have, for the first time in a long time, a province-wide capacity planning initiative and we have a capacity planning division, and ADM Patrick Dicerni will be speaking to it. He leads that.

We have started some really, I would say, important work around capacity planning across the system, but as we said earlier, you have to start somewhere. So one of the areas of focus is indeed long-term care. But keeping in mind that this isn't as simple as saying "X number of long-term-care beds," because that X depends on—

Mr. Bill Walker: I didn't say it; you did.

Hon. Dipika Damerla: I'm just making the argument that it depends on Y amount of home care, for instance. It's a very sophisticated, very complicated subject, but an important one. I just wanted to reassure everybody that work is ongoing.

I'd like to invite Patrick to come and give us more detail on what we are working on.

The Acting Chair (Ms. Catherine Fife): Could you please—once you get settled down—introduce yourself to the committee, with your title as well?

Mr. Patrick Dicerni: My name is Patrick Dicerni. I'm the assistant deputy minister of the strategic policy and planning branch within the Ministry of Health and Long-Term Care.

MPP Thibeault, thank you very much for your question. Building off the remarks of Associate Minister Damerla—

The Acting Chair (Ms. Catherine Fife): Would you mind speaking just a little closer to the mike? Thank you.

Mr. Patrick Dicerni: No problem. Is that better? Great. I was making some notes to myself during your personal story and anecdote, and thank you for sharing. It speaks to the need, and this is what the minister touched on, of ensuring that we have the right care at the right time in the right place for our family, our loved ones or our friends when they need it and pivoting that to looking forward in the Ministry of Health over the next 10, 15, 20 or 25 years to make sure that we have that right service mix and model of care ready for the future. That's why the Ministry of Health, about a year ago now, stepped into a process that we're calling capacity planning.

Let me step back and explain how we arrived at the need for that and how we're framing it, because capacity planning, as we've gone on this journey over the last eight months or so, can mean a lot of different things to different people. Depending on how we define it, it's about bricks and mortar, it's about the right health force mix and it's about service interventions and models of care changes.

Capacity planning is the process of understanding what the demand across the system is to ensure that we have the right supply to meet it. As I mentioned, that's everything from the people to the bricks and mortar to health care interventions.

In a health care context, capacity planning is the process of understanding what our population health needs are going to be and designing a system to meet those needs, as I said, going out until about 2040 as we're looking at our planning horizon.

The work is to make sure that we align our policy, our funding decisions and our supply that I mentioned across the health care system with the needs of the population,

or the demand side. To begin this process, we must define what our population health needs are, and this includes demographic characteristics that provide insight into how the population differs on the basis of age, geography, socioeconomic level and culture.

Trends in demographics—for example, age, income, education, physical activity, nutrition—gives us a good sense of enhancing our understanding of what the overall health of the population is, including the types of health conditions we're going to see in the future or that are prevalent around the corner.

These demographic trends allow us, by extension, to estimate what the future overall health of the Ontario population is going to be, as well as getting into even level of detail around prevalence of certain health conditions and how we need to plan for our system around that.

For the purposes of capacity planning, the overall health and prevalence of various health conditions in the population are referred to, in my area of the ministry, as what our population health needs are.

A provincial framework that supports consistency and innovation in approaches to capacity planning will consider four main elements that I'll talk to the committee about today.

The first is the question of access: A person-centred health care system needs to look at the needs of Ontarians regardless of whether or if they're accessing the current health system as we know it.

Next is an improved understanding of population health needs at the provincial, regional and local levels for now and into the future.

I'll speak a little bit about the work that our LHINs is doing currently in this space. It's about an alignment of capacity planning activities across the health care system, focusing on common objectives and supporting province-wide and community profiles. As I mentioned, the ministry has stepped into this space over the last while. Our LHINs have been actively doing this for their own local geographies for a while, and it was time that the ministry put a provincial lens on that—not to step on top of or duplicate the work that was going on within our local health integration networks but to really complement it and provide a provincial-level focus to it.

The last element is models of care: multiple approaches to health care delivery, including alternative innovative approaches to model of care and creating a system that's flexible and nimble enough to accommodate those innovations going forward into the future.

This framework is intended to provide planners all over the ministry in local—

The Acting Chair (Ms. Catherine Fife): You have two minutes.

Mr. Patrick Dicerni: I'll hustle along. Let me just skip ahead to a couple of tangible elements.

There are three tangible activities that are going on with respect to capacity planning right now. First is some work that we're doing with partners in the health care system, like CIHI and like the Institute for Clinical Evaluative Sciences—ICES—that is really drilling down on giving us some population health-needs models for different cohorts within the health care system. This ties into a second piece of work—and the minister touched on this. We are frontloading or starting this work with the cohort that is destined for long-term-care or continuing care needs. When we get a sense of what the care needs are of that cohort, we can start planning for alternative service delivery that isn't confined necessarily to long-term-care homes but is keeping people successful for longer periods of time within their home, which, as you shared, MPP Thibeault, is where your folks wanted to have their care and where they were the most comfortable. It's about keeping those people as successful in their homes for as long as possible.

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The second element that I wanted to talk about is what we're calling a proof of concept, specifically in the dementia space. Our deputy challenged us to take dementia capacity planning on as one of the early disease states or issues, just because of the complexity that represents, the prevalence that is increasing and the fact that this touches on multiple elements of the health care system. If we can do a better job and a better job in the future of planning for those experiencing dementia, some of the other areas that we'll move to after should be, relatively speaking, more simple than treating and appropriately planning for care for this cohort.

The Acting Chair (Ms. Catherine Fife): Thank you very much. I'm sorry, but your time has elapsed.

Mr. Walker, you have the remainder of the time in this cycle.

Mr. Bill Walker: Thank you very much, Madam Chair.

The Acting Chair (Ms. Catherine Fife): Do you have questions for him?

Mr. Bill Walker: I may have questions. I want to just finish up on one last question before the time runs out.

Minister, you shared with me that you actually added $14 million to the assistive devices. On page 117 of the estimates book, when I look at interim actuals from 2015-16, $483,784,000, and your estimate of $464,128,200, that shows me a $19,655,800 decrease than the actuals from last year. I'm just trying to figure out the math here.

My question, obviously, that I have is: Why would you be cutting that funding to this valuable program, putting more vulnerable Ontarians at risk, when your actuals show what you spent last year?

Dr. Bob Bell: Thank you. Just give us a second, Mr. Walker, if you would.

Mr. Bill Walker: While you're looking, I'll just share with you, as well: Jeff Preston had a nine-month wait just to get his wheelchair, which should have been replaced two years ago, assessed. He was, frankly, terrified that it was going to fall apart, and he was going to be bedridden and possibly lose his employment for nine months. There's no disputing this. This is an absolute true fact. He's from Port Elgin. He lives in London. He went to

one of the members and didn't get anywhere. That's why he finally reached out to me and members of my caucus. Thankfully, after us putting some pressure on, he was able to get into the queue and he did get an assessment, so that's great news. But for nine months, every day he woke up—

Hon. Eric Hoskins: I'm happy to address the situation of this particular individual you've referenced. The information we have was that when he was assessed by the occupational therapist on April 25 of this year, in fact his wheelchair was assessed to be functional at that time of assessment by the occupational therapist. Nonetheless, my understanding is that due to the age of the wheelchair, he was deemed to be eligible for a replacement.

Forgive me, I suspect you have a much better understanding than I do, but what I've been informed of is that his wheelchair and his particular circumstances are quite unique and complex. For example, the replacement of the wheelchair—even just to mould the seat required for his specialized wheelchair, just the moulding of the seat is a procedure that requires five weeks to undertake the manufacture and the moulding of it. But he was and has been provided with an interim loaner wheelchair during this interim period, if you will.

My understanding was that, because often with our assessors and for maintenance, repair and replacement, for example, there is a prioritization in terms of the degree of urgency. When his wheelchair was assessed, the information that I have is that it was assessed to be functional, but due to the age of the wheelchair he was eligible for a replacement, but due to the complexity of his situation and the wheelchair, there is a longer time period than would normally be anticipated because of, for example, the sorts of issues that I referenced with regard to the time it would take to mould the seat of the chair itself.

Mr. Bill Walker: I appreciate what you've done once he got into the queue, but what we're missing here—I believe the words that the associate minister used were "right care, right time, right place." A nine-month wait for an assessment to happen cannot, I don't think, be acceptable to you to be the right time, the right place, the right care.

These people are vulnerable. They need that. If it had broken, I'm sure he would have gotten good service, but he lived in fear for nine months. Nine months is not an acceptable time when it's something you have to have.

Hon. Eric Hoskins: Thank you for reminding me of that. We have over 5,000 assessors, health care professionals, who are available across the province. They make every effort to be able to see individuals promptly. In fact, within the contracts or agreements with those who maintain and repair our wheelchairs, there's a requirement that a loaner wheelchair is offered. But there are also specific circumstances where, due to the complexity of the apparatus itself—and there may be a more limited number of assessors, individuals or entities that can repair and maintain certain unique wheelchairs—there may be a difference in terms of the ability to access that limited number of those individuals who would have sufficient expertise to look at unique circumstances.

Mr. Bill Walker: I would concur, but I can't imagine that you're going to agree that nine months just to get assessed is an acceptable time period when it's his only form of being mobile. That has to be improved.

Dr. Bob Bell: Minister, could I draw back to the question of $11 million?

Hon. Eric Hoskins: Yes.

Dr. Bob Bell: If we look at estimates 2015-16 to estimates 2016-17, Mr. Walker, there is an incremental allocation of $11,800,000. You're looking at Q3 interim actuals from 2015-16 and doing a comparison across those lines. Just to let you know, the incremental funding is related to our estimates around the inclusion of grants for colostomy supplies being increased over the next year, as well as the utilization for some services to increase. We're also looking at other services that could be affected during the 2016-17 year in terms of eligibility for services. We've got a number of issues, looking at appropriateness for various elements that are supplied through the ADP, under review at present. Remembering also that the interim actuals are rarely exactly what we have in terms of the actuals for the complete fiscal year, these are estimates provided at Q3.

Mr. Bill Walker: Can you clarify for me, then, is it truly a $14-million increase in that overall Assistive Devices Program from last year to this year?

Dr. Bob Bell: If we compare the 2015-16 estimates to—

Mr. Bill Walker: Actuals. I don't really care about estimates; I want to know the actuals. What did you spend in 2015-16 and how much are you going to spend in 2016-17?

Dr. Bob Bell: At the time of the preparation of these materials, we wouldn't have the 2015-16 actuals even completed at the time of the development of the estimates for 2016-17.

Mr. Bill Walker: So how can you tell me you're adding an additional $14 million, then, if you don't know what last year's final was?

Dr. Bob Bell: What we're doing, of course, is estimate to estimate. Budget to budget is what we're talking about—

Mr. Bill Walker: Are you then saying there's a $14-million increase from estimate to estimate?

Dr. Bob Bell: I'm saying there's an $11,800,000 increase in this line, as you can see on page 117 of the estimates book.

Mr. Bill Walker: Okay. Thank you.

The Acting Chair (Ms. Catherine Fife): We have one minute left. I don't know if you would like to use that time, MPP Walker.

Mr. Bill Walker: Yes. It's back to your capacity planning. I agree that you need to do that, and there are all kinds of complexities, but I still struggle with how you came out somewhere and said "30,000 beds." Did you never need 30,000 beds? You can give me all the spin, but there are people who do not have a bed who

need a bed. You said—not me, your government said—that 30,000 beds was what you were going to build. I trust you based that on fact and what you knew you had to do. You're trying to spin this so that now, you're going out and doing some other stuff and it's complex. I get all of that, but why did you say 30,000? And if you don't really have 30,000 as a need, why don't you retract it?

Hon. Dipika Damerla: Do I have time to answer this?

The Acting Chair (Ms. Catherine Fife): You unfortunately don't. Mr. Walker has the last word.

I would like to thank both ministers, the associate minister and the multiple staff who spent the afternoon here. Thank you very much for being here.

This committee stands adjourned. We will reconvene on Tuesday, May 17, at 9 a.m.

The committee adjourned at 1800.

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