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SP-4

Standing Committee on Social Policy

Estimates

Ministry of Health

Committee business

1st Session
43rd Parliament

Monday 14 November 2022

Journal des débats (Hansard)

SP-4

Comité permanent de la politique sociale

Budget des dépenses

Ministère de la Santé

Travaux du comité

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Lundi 14 novembre 2022

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Clerk: Vanessa Kattar

Présidente : Goldie Ghamari
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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON SOCIAL POLICY

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Monday 14 November 2022

Lundi 14 novembre 2022

The committee met at 0900 in committee room 2.

ESTIMATES

MINISTRY OF HEALTH

The Chair (Ms. Goldie Ghamari): Good morning everyone. The Standing Committee on Social Policy will now come to order. The committee is about to begin consideration of the estimates of the Ministry of Health for a total of three hours. As this is the first ministry before committee, I would like to take this opportunity to remind everyone that the purpose of the estimates committee is for members of the Legislature to determine if the government is spending money appropriately, wisely and effectively in the delivery of the services intended.

As Chair, I will allow members to ask a wide range of questions pertaining to the estimates before the committee to ensure they are confident the ministry will spend those dollars appropriately. In the past, members have asked questions about the delivery of similar programs in previous fiscal years, about the policy framework that supports a ministry approach to a problem or service delivery, or about the competence of a ministry to spend the money wisely and efficiently. However, it must be noted that the onus is on the members asking the questions to make the questioning relevant to the estimates under consideration.

The ministry is required to monitor the proceedings for any questions or issues that the ministry undertakes to address. I trust that the deputy minister has made arrangements to have the hearings closely monitored with respect to questions raised so that the ministry can respond accordingly. If you wish, you may at the end of your appearance verify the questions and issues being tracked by the research officer. Are there any questions from the members before we start?

I'm now required to call vote 1401, which sets the review process in motion. We will begin with a statement of not more than 20 minutes from the Minister of Health.

Minister, the floor is yours.

Hon. Sylvia Jones: Thank you very much, and good morning, Madam Chair and members of the committee. Thank you for the opportunity to speak with you today about the work of the Ministry of Health for the past year.

Before I begin, I would like to take a moment to thank each and every member working in our health care system. On behalf of Premier Ford and our entire government, we are truly grateful for everything you do each and every day to care for Ontario's patients. I also want to take this time to thank the public service at the Ministry of Health and Ontario Health who have also worked hard every day to improve Ontario's health care system.

The Ministry of Health consistently and constantly works towards one of government's main areas of focus: to build a better connected health care system that is centred around the needs of patients, and at the same time the ministry is also leading the ongoing response to the global COVID-19 pandemic. Supported by the Chief Medical Officer of Health and other public health experts, the province made significant strides in its efforts to fight COVID-19 in the past year. The ministry worked diligently to continue implementation of our COVID-19 vaccine rollout. This, of course, included prioritizing population for vaccination in accordance with an ethical framework, advice from the Chief Medical Officer of Health and other experts, and recommendations from the National Advisory Committee on Immunization.

The province began by researching those at highest risk of infection and serious illness from COVID-19. We were also focused on reaching individuals in communities where COVID-19 was spreading disproportionately. Equitable vaccine distribution was supported by community-driven efforts through the High Priority Communities Strategy.

This also included a provincial mobile vaccine strategy that contributed to increased vaccination for the hardest-hit populations. With this stable and increased vaccine supply, Ontario was able to accelerate vaccine doses. Everyone aged 18 and above was eligible for a first dose by May 2021. Booster doses were also accelerated during this time. This has been a critical part of the response to the Omicron variant and also help protect our hospital and intensive care unit capacity.

The province also implemented a last-mile strategy to reach eligible individuals who had yet to receive a first or second dose, focusing on smaller, community-based and easy-to-access settings for vaccinations. This, of course, included mobile clinics; community-based pop-ups; dedicated clinics for families and people with disabilities; GO-VAXX bus clinics; and town hall meetings in multiple languages.

The ministry also continued to provide Ornge with funding to lead and support Operation Remote Immunity, which administered the COVID-19 vaccine in northern and 31 fly-in First Nations communities, as well as

Moosonee. Operation Remote Immunity was completed in February 2022, and, in total, its COVID-19 vaccine clinic administered over 42,000 doses. Ontario made more than $1 billion available to implement this province-wide vaccination program, and our collective efforts enabled Ontario to achieve one of the highest vaccination rates in the world, with more than 90% of Ontarians aged 12 and over having received at least two doses of the vaccine by February 2022. Vaccines have been key to keeping our province open and we are very thankful to public health units, hospitals, pharmacies, as well as many other health care workers and community members for their hard work to get people vaccinated.

In addition to accelerating vaccine doses, the province took further decisive action to respond to the Delta and Omicron variants, which helped protect our hospital and intensive care unit capacity. We implemented a robust and responsive testing strategy, including prioritizing lab-based PCR and molecular testing for vulnerable populations and high-risk settings, and extensive distribution of free rapid antigen tests to the general public, including in our publicly funded schools. We deployed comprehensive plans to gradually and cautiously lift public health and workplace safety measures, reopen the province and manage COVID-19 for the long-term, all while being guided by the ongoing assessment of key public health and health system indicators.

In consultation with the Chief Medical Officer of Health, Ontario released its Roadmap to Reopen in May 2021 and a plan to safely reopen Ontario and manage COVID-19 for the long-term in October 2021. But as the Omicron variant arrived in Ontario in late November 2021, and as key indicators continued to worsen, the province needed to adjust and strengthen its COVID-19 response. We needed to pause parts of these plans to safely reopen the province. By the end of January 2022, key public health and health system indicators were improving or remained stable, and based on the advice of the Chief Medical Officer of Health, the province began to safely and gradually ease public health and workplace safety measures.

In addition to focusing on the pandemic response in 2021 and 2022, the Ministry of Health continued to support the implementation of the government's key priority: to transform and modernize the health care system to be centred on the needs of patients and families. We continued our efforts to improve the patient and caregiver experience and support our health care providers and made significant investments. The results include more hospital capacity; more care options for patients; improvements in home and community care; the creation of new Ontario health teams; thousands of more workers added to the health care system; and an expanded system of comprehensive and more connected mental health and addition services.

The province invested in additional hospital beds and targeted hospital investments, particularly in areas where there are high-growth needs, and to address significant demands for services while ensuring all communities have access to high-quality health care.

For example, in Thunder Bay, ministry investments are supporting the planning and design of a cardiovascular surgery program at Thunder Bay Regional Health Sciences Centre. This will mean that, for the first time, cardiac surgery will be regularly performed in northwestern Ontario, helping to address surgical wait times and improving access to life-saving care.

In Windsor and Essex county, our investments are supporting the planning for a brand new, state-of-the-art acute care hospital. Once complete, this will add more hospital beds and expanded services for individuals and families living in the region.

Ontario is making the single-largest hospital infrastructure investment in the province's history by making a multi-billion-dollar investment to build a new, state-of-the-art Mississauga Hospital and expanding Queensway Health Centre.

0910

The province is supporting the transformation of Peel Memorial into a new hospital, funding the construction of over 250 net new beds at the site and making investments to expand the urgent care centre to a 24/7 operation, and the ministry's investments to support the expansion of the Southlake Regional Health Centre's adult in-patient mental health unit will enable the hospital to care for more than 400 additional patients each and every year.

We are also taking action to address the pandemic's impact on the ability to perform scheduled surgery. As part of our plan to address the surgical backlog, we've made additional investments to enable Ontario's hospitals and community health sector to perform more surgeries, MRI and CT scans, and procedures, including on evenings and weekends, and we are investing in projects that are helping hospitals build capacity to do more surgeries, by supporting new equipment and training more operating room and diagnostic imaging staff.

Faced with health workforce pressures stemming from the pandemic, the province continued to add more health care workers in the system. We supported a number of initiatives to recruit and support nurses, including:

—the Nursing Graduate Guarantee program, which supported the hiring of more than 500 nurses in 2021-22, and has already supported 1,200 nurses to date in 2022-23;

—providing Ontario's nurses with a lump-sum retention incentive of up to $5,000 per person;

—additional investments of up to 2,000 additional nursing students at publicly assisted colleges and universities; and

—initiatives to deploy internationally educated nurses to hospitals and other health care settings.

Ontario is investing $342 million, beginning in 2021-22, to add over 5,000 new and upskilled registered nurses and registered practical nurses, as well as 8,000 personal support workers. This helps support the government's commitment to invest up to $1.9 billion annually by 2024-25 to create more than 27,000 new positions for personal support workers, registered nurses and registered practical

nurses in long-term care, to meet the direct care commitment of four hours of care per day.

In recognition of the important role that personal support workers play in Ontario's health and long-term-care system, the government invested $201 million in 2021-22 to train up to 6,400 new personal support workers in the health and long-term-care sector. In 2021-22, Ontario also invested an additional $683 million to extend the temporary wage enhancement for personal support workers and direct support workers. This increase helped attract and retain workers in these critical sectors, to help stabilize, attract and retain the workforce needed to provide a high level of care during the COVID-19 pandemic. We are continuing to work with our health care partners to further expand and strengthen the province's health workforce, ensuring they have the tools and resources to continue providing world-class care to Ontarians.

In April 2022, the province announced an additional investment in home care of $1 billion over the next three years, to improve access and the quality of care, to keep the people of Ontario in the homes they love longer and reduce pressure on other health care settings.

This is all on top of the work we are currently doing with our regulatory college partners, the College of Nurses and the College of Physicians and Surgeons, to shore up our health resources. Earlier this year, the ministry directed the regulatory colleges to do everything possible to speed up the process to get more internationally educated nurses into our health care system faster. We worked together to bring forward regulatory changes that broke down barriers, to help people from abroad register more effectively to work in Ontario, and I am proud to say that our plan is working. The College of Nurses has registered more new nurses than ever: over 12,800 new nurses registered in 2022.

In addition to investing in the health workforce, we've also supported more connected services between a patient's different care providers by continuing to support and expand Ontario health teams across Ontario. Ontario health teams bring together health care providers from across health and community sectors, including primary care, hospitals, home and community care, mental health and addiction services and long-term care as one collaborative team to better coordinate care and share resources.

An Ontario health team is responsible for delivering care for their patients, helping them experience easier transitions from one provider to another and directly connecting them to different types of care. Through Ontario health teams, patients will have convenient access to connected providers who can better meet all of their health care needs. Patient, family and caregiver engagement and partnership is a core pillar of the Ontario health team model, and they are expecting to deliver on this through their planning and implementation.

We're seeing more examples of accessible and connected services, including in patients' homes and in the community. This includes virtual care, expanded roles for community paramedicine, and the Ontario health teams bringing together mental health and addictions providers with other health and social services to support priority populations.

Over the last year, the province announced 12 new Ontario health teams, in partnership with Ontario Health. With the addition of these new teams, there are a total of 54 Ontario health teams established across the province. The Ministry of Health has also recently invited four new potential teams to complete full applications to become approved Ontario health teams. Once approved, these remaining teams would result in the province achieving its goal of full provincial coverage, ensuring everyone has the support of an Ontario health team.

I will soon pass it over to my colleague the Associate Minister of Mental Health and Addictions to take the remainder of my time today to share more of our work to improve mental health services for Ontarians. But before I do that, I want to talk about our plans to stay open from March and August of this year.

In March 2022, we unveiled our first plan to stay open, which filled gaps in three main areas, including expanding the province's health workforce, shoring up domestic production of critical supplies and building more hospital beds. This work is already in motion. We've added thousands of health care workers into Ontario's workforce. We've given personal support workers a well-deserved permanent raise.

The Chair (Ms. Goldie Ghamari): Minister, you have five minutes left.

Hon. Sylvia Jones: We've given Ontario nurses a $5,000 retention bonus. We're building brand new medical schools and paying, for aspiring nurses, for textbooks and tuition if they want to serve in underserved communities.

In August 2022, we unveiled our Plan to Stay Open: Health System Stability and Recovery. This is a five-point strategy to further bolster Ontario's health care workforce, expand innovative models of care and ensure hospital beds are there for patients when they need them. Our plan is working. We have already added over 12,000 more health care workers and continue to add more each and every month.

But in the face of some increased pressures, we know that even more needs to be done to improve patient care and support our health care workers. We can no longer accept the status quo, and there are some who will fight for status quo no matter what. They're ideologically opposed to change and improvements. We won't accept that; we cannot accept that. People deserve—want—better health care: shorter wait times for emergency services and surgeries; better quality that takes the guesswork out of navigating a complex system; more virtual and digital options, including for people receiving care at home.

I hope that I can discuss these further in responding to questions, but at this point, I'd like to turn it over to my colleague the Associate Minister of Mental Health and Addictions.

Hon. Michael A. Tibollo: Thank you, Minister Jones, and good morning, Madam Chair and members of the committee.

In 2021-22, the province invested $175 million thorough our Roadmap to Wellness and since 2019 has invested $525 million in net new annualized funding for mental health and addiction services and supports. With these investments, we're addressing urgent gaps in care, creating new and innovative evidence-based services and enhancing those supports in a range of priority areas. Through these efforts, we will build a continuum of care in every community across Ontario capable of guiding clients through intake, treatment and providing them with post-treatment wraparound supports.

We've increased funding for community-based child and youth mental health services. Our youth wellness hubs offer low-barrier mental health supports, primary care services and early interventions to Ontarians aged 12 to 25. There are presently 22 established in the province, with another six under development right now.

0920

As the number of children and youth with eating disorders has risen sharply since COVID-19, the province has made important investments to support specialized intensive care, which includes additional in-patient surge beds and day treatment spaces at four pediatric hospitals.

The ministry also supported the development and expansion of the Ontario Structured Psychotherapy program for people experiencing anxiety and depression. This is the first of its kind anywhere, providing clients with access to a range of services, including evidence-based, cognitive behavioural therapy-related approaches that are matched to their specific needs. This program will ensure clients pay zero out-of-pocket costs and receive help close to home.

Recognizing the impact that the pandemic has had on health care workers and their mental health, Ontario also dedicated funding to provide continued rapid access to expanded new treatment options and supports specifically focused on the needs of front-line health care workers. These services include self-directed resources, online peer discussion groups, confidential one-to-one supports from a clinician and workplace mental health training.

Our investments in five mobile mental health and addiction clinics are providing services directly to individuals living in rural, remote and underserviced communities across Ontario. These clinics reduce the need for people to travel to find services, serve more clients with greater convenience and offer supports to those with severe conditions before they may experience crisis.

The Chair (Ms. Goldie Ghamari): One minute left.

Hon. Michael A. Tibollo: Ontario has also invested mental health dollars for justice-involved individuals, including continuing to support police services who are responding to mental health crises through Mobile Crisis Intervention Teams. We've made additional investments to support a wide range of supportive housing needs and have increased the number of rent-supplemented supportive housing units to support people who are designated alternate-level-of-care in a hospital to transition to supportive housing in the community, which also helps decrease pressures on the high-cost hospital system.

We have also increased funding for rent supplements and have modernized homes for special care, now called the Community Homes for Opportunity program. We've made investments in our dedicated supportive housing stock to maintain the current supply of housing for Ministry of Health clients.

All these investments, including our recent investment in February 2022 to the Addictions Recovery Fund to increase the number of treatment beds over three years, has also added 400 treatment beds, 7,000 treatment spots—

The Chair (Ms. Goldie Ghamari): Thank you very much, Minister. That's all the time that we have. I'd like to thank Minister Jones and Minister Tibollo for their presentation.

We will now begin question and answers, in rotations of 20 minutes for the official opposition members of the committee, 10 minutes for the independent member of the committee, and 20 minutes for the government members of the committee, for the remainder of the allotted time. As always, please wait to be recognized by myself before speaking, and all questions and comments will need to go through the Chair.

For the deputy ministers, assistant deputy ministers and staff: When you are called on to speak, kindly provide your name and your title each time so that we accurately record in Hansard who we have speaking.

I will now start with the official opposition. MPP Gélinas, you may begin. You have 20 minutes.

M^me^ France Gélinas: Thank you. I'd like to thank the minister and the associate minister for mental health for your presentation this morning. It's greatly appreciated.

As you know, these sessions used to be many, many hours; now we only have three hours. So my questions will be very focused, and I would appreciate a very focused answer. I don't mean to be rude or anything, but I will have a direct question and I would appreciate a direct answer. If it doesn't come directly, expect to be interrupted, and I'll ask my question again so that I get answers to my questions. As the Chair has said, we have an important job to do to make sure that the money is well spent. And we all want the money to be well spent.

My first question is about—in the last 15 years, I've always started estimates with primary care, so I figure: Why not start with primary care again this year? So my first question has to do with primary care. What is the status of the primary care recruitment and retention program right now for 2021-22, as it was in the estimates book?

Hon. Sylvia Jones: So as I mentioned in my opening remarks, we've actually worked very well with both the college of nurses and the College of Physicians and Surgeons of Ontario to make sure that individuals who have submitted applications are getting their licences reviewed, assessed and, if appropriate, approved in an expedited manner. We've seen—

M^me^ France Gélinas: That's not what I'm talking about. I'm talking about the funding for primary care recruitment and retention. This is money that is given to

primary care agencies for recruitment and retention—not the licensing; the funding.

Hon. Sylvia Jones: I think it's all packaged together, because it is important to acknowledge that while we are building the system, we are actually trying to ensure—and working very actively with the colleges to make sure that work is going on.

I will turn it over to Deputy Dr. Zahn.

Dr. Catherine Zahn: Thank you very much, Minister.

I'm Dr. Catherine Zahn, Deputy Minister of Health for Ontario.

There are a number of initiatives in place that, by necessity, are related to all main negotiations.

To answer the question in a more fulsome fashion, I'm going to defer to ADM Patrick Dicerni to speak about it.

The Chair (Ms. Goldie Ghamari): Please make sure to state your name and title for the record before you begin.

Mr. Patrick Dicerni: I'm Patrick Dicerni, the assistant deputy minister of health programming delivery.

Good afternoon, Madame Gélinas. Your question related to primary care.

The Ministry of Health and the Ontario Medical Association recently signed a mediated agreement to cover the period between April 1, 2022, going through March 31, 2024. A component of that agreement was to expand the popular family-health-organization physician model by 720 physicians, or 60 physicians per month, in 2022-23 and an additional 480 physicians, or 40 per month, in the year of 2023-24. Those spots are filled through two streams, one stream being a priority stream for applicants in the areas of a rurality score above 30 and where physicians are joining an academic FHO, an Ontario Health-recommended FHO etc. There's also a regular stream of applicants who are processed on a first-come, first-served basis. These numbers do not include replacements for physicians who have retired or are moving on. I do want to note that managed entry into these agreements has no impact on entry into other primary care models, which have a more open, expansive entry component, as opposed to the family health organization model.

M^me^ France Gélinas: Would those include community health centres and Aboriginal health access centres?

Mr. Patrick Dicerni: No, those would be just the family-health-organization model entries.

M^me^ France Gélinas: Okay. Thank you for your answer regarding physicians.

If we look at the position of nurse practitioners in community health centres, Aboriginal health access centres, nurse practitioner-led clinics—we'll start with those three before I move into family health teams. I have the estimates book in front of me. What programs exist in order to grow the number of these positions and give more people access to primary care? I'll leave it open, but then I'll drill down.

Mr. Patrick Dicerni: Thank you very much for the question. If I've understood your question correctly, you're speaking about how we augment non-physician resources within two primary care models, i.e. other allied health professionals. Every year, there are discretionary funds made available to respond to solicited or unsolicited proposals into some of the models that you reference there.

We do work closely with the Ontario Health agency to understand where there are assets that can benefit other care providers as well as where there are deficits of assets. The ministry is always on receive with respect to unsolicited proposals for articulated cases of need, whether that be from migration of services or resources. OHTs, going forward, are going to be a critical component in spreading our scarce assets, in some cases, across a broader number of care providers.

0930

M^me^ France Gélinas: How big is that discretionary fund that is made available? How much money are we talking about?

Mr. Patrick Dicerni: I don't want to provide you with an inaccurate figure. Let me take that back. It's a number that we can provide to you.

M^me^ France Gélinas: Okay. I would be interested in getting that number for, let's just say, the last three years, just to see how it changed.

Drilling down, I represent a northern riding. I can tell you that in Capreol, the only access to primary care is through the nurse practitioner-led clinic. They have 200 people on their wait-list. They have nurse practitioners who are willing to go work in Capreol, yet they have no money to fund new positions in Capreol, and they've put in a request for a new nurse practitioner. We're talking a $100,000 request. This request has not been acknowledged. It has not been responded to, and yet we have 2,000 people in Capreol on their wait-list.

Capreol is but one. I can go Coniston. Coniston is another little community in Nickel Belt that has zero access to primary care, that has a nurse practitioner, asking—we're not even talking millions of dollars here.

The requests are there. There are discretionary funds that are supposed to be there in those situations, and yet nothing happens. How come? How come those funds are not being made available? How come those requests for proposals are not being answered?

Hon. Sylvia Jones: If I may, Chair—

The Chair (Ms. Goldie Ghamari): Yes, Minister?

Hon. Sylvia Jones: The unsolicited proposal requests that come in have a process that includes an assessment that happens at the regional level to ensure that there aren't sufficient resources in the regional area, and then, of course, the further review and commitment internally to assess need as well as fiscal realities.

I don't know, Deputy Zahn, if you want to get further into that.

Dr. Catherine Zahn: I think that's correct. We have a deep understanding—

The Chair (Ms. Goldie Ghamari): Please just state your name and title.

Dr. Catherine Zahn: My apologies. I'm Dr. Catherine Zahn, Deputy Minister of Health.

I lost my train of thought; sorry.

With respect to the mismatch in Ontario of primary care, both geographically and the balance of primary care

and specialty care, which is being addressed, as the minister indicated, there are a number of areas that are problematic. I will tell you that we will go back and review what we have and ensure that there is attention brought to areas of high need.

M^me^ France Gélinas: We are here to make sure we use our money wisely. I am but one riding in the north. Every riding in the north is the same. We have nurse practitioners who live in the north who want to work in the north. I can talk about Wahnapitae First Nation. They fundraise to pay for the nurse practitioners to come to Wahnapitae. They have a nurse practitioner. We have, in my riding, 40,000 people without access to primary care. We have those nurse practitioners who have wonderful skills to take on those patients. Otherwise, they all end up at Health Sciences North, which, right now, on their website, is full to 136% capacity. The wait time in ER is huge. You can look at the website just as much as I do. We'll can talk about hospitals later.

How could it be that a request that has been done in March—they sent a further request, but yet they never hear from you, nothing. If you are doing this assessment of need and the regional assessment and all of this, how come you can't even tell them that?

Hon. Sylvia Jones: I don't want to speak to a specific example, because I don't have the details, but it may be a case where the regional Ontario health teams are building those collaborative teams together and they want to ensure that the nurse practitioners are an active part of those regional Ontario health teams. As recently as September, three additional regional Ontario health teams were announced in northern Ontario.

I won't get into the specifics of the example that you gave, because I don't have the detail. What I will tell you is, as those Ontario health teams are chosen and billed out, then that will ensure that continuity and coordination between primary care, including nurse practitioners. I hope that helps.

M^me^ France Gélinas: I'm interested in money. Ontario health teams don't hire any staff. Ontario health teams link primary care providers together with hospitals, with long-term care. I get that. We don't have one in Nickel Belt, but that's beside the point. The idea is, really, we have primary care providers right now that have wait-lists of thousands of people that are unattached. Many of those people have severe chronic illnesses. They end up in the ER all the time.

Hundreds of thousands of dollars is not a whole lot of money for your ministry. The ADM has told us that you have discretionary funds to fund those, and yet nothing happens, so I'm really interested in finding out how much is this discretionary fund that is made available for primary care and where is it spent. Because when 40% of the people I represent don't have access to primary care, I cannot see how we would be not be high-needs. I represent northern rural populations who have access to those providers and don't have the money to hire them. I want to know where the money is going, because it's not coming to where I would say are areas of high need.

Hon. Sylvia Jones: One example that I can highlight to the committee is, we had a group of, I believe it was, six nurse practitioners that, during the pandemic, were funded to ensure that they could provide virtual care to primarily unattached patients. That model has turned out to be very effective for the community. In fact, funding for that particular nurse practitioner-led program has been extended. That would be one example of literally hundreds of proposals that come into the ministry and get assessed through both the Ontario health team as well as the ministry.

M^me^ France Gélinas: My next question—and I'll stick with nurse practitioners for a while—is, how come we only have 25 nurse practitioner-led clinics, although there are many other communities—Coniston being one of them—who would like to have a nurse practitioner-led clinic? Where does this idea that we only needed 25 come from, and why is it that they were never allowed to grow beyond 25?

Hon. Sylvia Jones: Again, I will go back to our Ontario health teams. When you have a model that ensures coordination between all health practitioners, you want to make sure that you are not setting up a separate system that discourages that coordination and that co-operation. That's why we have focused so aggressively on ensuring that all of Ontario has Ontario health teams that are prepared to work together in a coordinated fashion that ends up being a very patient-focused model.

We want to continue with that system so that we don't have diverging and, frankly, conflicting areas where you are setting up separate and apart—who are not necessarily working with the other health practitioners and specialists and mental health and addictions services—

M^me^ France Gélinas: But, Minister, you have to understand that those are communities that have zero access. There is no conflict; there is zero access.

The Chair (Ms. Goldie Ghamari): Five minutes left. I also would just like to remind members to not speak over each other because it's difficult to record for the purposes of Hansard. Thank you.

M^me^ France Gélinas: I have nothing against Ontario health teams, but where I come from, when there is zero access. It doesn't matter if you coordinate programs; there is zero access. There are health professionals right here right now in those communities that want to provide care. I will tell you, Minister, that there are nurse practitioners that open private clinics where people pay to gain access to primary care through a nurse practitioner. They cannot bill OHIP. They cannot find a job because the community health centres haven't seen a base budget increase, the Aboriginal health access centres haven't seen a base budget increase and the nurse practitioner-led clinics have not seen a base budget increase. Those nurse practitioners know that there is a need in those communities. They set up a fee-for-service where people in my community pay to gain access to primary care. So to talk to me about Ontario health teams is to completely disregard the fact that you cannot link to something that doesn't exist—zero access, no provider but a nurse practitioner who cannot find a salary anywhere because your government has not

increased the base budget of any of those primary care teams that work in the north.

0940

Back to the ADM: Have we seen a base budget increase for community health centres, for nurse practitioner-led clinics or for Aboriginal health access centres?

Mr. Patrick Dicerni: Madame Gélinas, I wish to answer your previous question regarding the discretionary funds—

The Chair (Ms. Goldie Ghamari): Can you please provide your name and title? Thank you.

Mr. Patrick Dicerni: ADM Patrick Dicerni, health program delivery.

With respect to our previous exchange, there is, for this fiscal year, $7 million available. That is set against approximately $75 million worth of unsolicited proposals. The ministry is currently reviewing the proposals, as the minister had said, in concert with the Ontario Health agency.

Mme France Gélinas: Was it the same amount the year before and the year before, the $7 million for a discretionary fund?

Mr. Patrick Dicerni: I would have to take that back.

Mme France Gélinas: Okay. And the $7-million proposals—so those are proposals that you have already received in this fiscal year?

Mr. Patrick Dicerni: I'm sorry; could you repeat the question?

Mme France Gélinas: You told me that there's $7 million available and you have $75 million worth of proposals. I'm just clarifying: Those are proposals for this fiscal year?

Hon. Sylvia Jones: Those are proposals in the pipeline.

Mr. Patrick Dicerni: Yes.

Mme France Gélinas: Okay. And—

Mr. Patrick Dicerni: And I do want to just comment on the breadth and plurality of those proposals. I don't want to specify that those are northern proposals; those are simply a tallying of the unsolicited proposals that have been received from primary care or allied health professional assets across the province.

Mme France Gélinas: Okay, thank you.

My question to you, Assistant Deputy Minister, was about base budget increases for the three models of primary care that I was talking about: Aboriginal health access centres, community health centre and nurse practitioner-led clinics.

Mr. Patrick Dicerni: There has been no base budget increase to the programs that you referenced.

Mme France Gélinas: Do you remember the last time there was a base budget increase?

Mr. Patrick Dicerni: No, Madame Gélinas, I do not.

Mme France Gélinas: I'll help you out: 12 years ago.

The Chair (Ms. Goldie Ghamari): One minute left.

Mme France Gélinas: Those are models that work in northern Ontario. Those are models that would help Health Sciences North not be full at 132% this morning. Those are models that would work in isolated communities.

Minister, I've gone to see you about Gogama, which went six years without access. We finally have an agency that will provide access to primary care to the people of Gogama, and yet they're still waiting on the final signature from yourself to be able to finally give those people access.

Hon. Sylvia Jones: My understanding, and I did look into that particular example, is that there was no gap in service in the Gogama example that you highlighted a couple of weeks ago with me. In fact, people are being served, and there is no gap. So there's a disconnect between what you shared with me and what I am hearing from people on the ground.

The Chair (Ms. Goldie Ghamari): Thank you very much. That concludes all the time we have for this round.

We'll now turn to the independent member for 10 minutes. MPP Shamji, you may begin.

Mr. Adil Shamji: Minister Jones, Minister Tibollo, thank you for being here. Dr. Zahn, it's a pleasure and honour to meet you for the first time. My questions will be slightly more broad, because I have less time; forgive me.

I'll begin by asking: Currently, we have a massive shortage of health care workers, vaccination is underwhelming, critical care is overwhelmed, the surgical backlog is through the roof. The CPSO is saying that even though a public health emergency has not been declared, we are under analogous circumstances. In your opinion, is this a question of lack of financial resources, or is it related to something else, like leadership or judgment?

Hon. Sylvia Jones: Well, very respectfully, I think it is related directly to a worldwide and, certainly, national phenomenon of health human resources.

I've just returned from an FTP—federal-provincial-territorial—meeting in Vancouver, where all Canadian health ministers shared what they were doing in their territories and provinces. After the discussion and examples that were given, we had a conversation internally, and the reality is, Ontario is doing everything that all other provinces have started or are doing as well.

This is an example of where all hands are on deck. We are, as I said, working with the CPSO; we're working with the College of Nurses. We're making sure that people who want to practice in health care in the province of Ontario are getting those licences reviewed, assessed and, ultimately, approved, if appropriate. We're training more nurses. It's the first time in decades that we have new medical schools opening in the province of Ontario.

We're doing short-, medium- and long-term goals, and the reality is that this will take time. We're working on the fast things as quickly as we can, but we're also ensuring that in the long term, we don't have problems that we've seen from, frankly, not enough focus on training and retaining.

Mr. Adil Shamji: Thank you for that. So from what I'm understanding from your answer, this is a shortage-of-health-care-workers issue, primarily. Typically in the private sector, if there is a shortage of workers, wages are typically increased, yet this has proven not to be the case amongst our nursing colleagues. Why is that?

Hon. Sylvia Jones: Well, in fact, we have given, provided a $5,000 retention thank-you for full-time nurses who practised in the province of Ontario through COVID-19. There is no doubt that it was a very challenging time and continues to be a challenging time, and that acknowledgement of a $5,000 retention was something that our government wanted to do, to ensure that people understood the value and the importance of retaining those employees.

Mr. Adil Shamji: Thank you. And of course, Bill 124 doesn't just affect nurses; it affects a variety, a large number of publicly funded health care professionals. What incentives have been offered to those?

Hon. Sylvia Jones: Well, I've mentioned in my opening comments that we have increased personal support care workers' wages by $3, and then, in fact, kept them at that. Because again, we have a system that relies very heavily on—whether it is nurses, whether it is registered nurses, RPNs, PSWs, we want to make sure that people are encouraged and incentivized to stay in those programs, particularly after our government has also, in many situations with PSWs and nurses, in particular through our Learn and Stay program, provided free training and free tuition and books for nurses—

Mr. Adil Shamji: So for porters, lab technologists, social workers: What are the incentives for them?

Hon. Sylvia Jones: What we have seen is we have seen a motivation and an encouragement during COVID-19, when individuals who could not work remotely, who did not have that option, were given incentives, and of course I've highlighted two in particular: the personal support workers and the registered nurses.

Mr. Adil Shamji: I'm sorry; I didn't hear the answer to porters, lab technicians, social workers and the variety of other health care professionals that are the backbone of our health care system.

Hon. Sylvia Jones: As I have mentioned, we have done incentive programs that have included RNs and PSWs. We saw, in particular, in those two professions a need to acknowledge that there was no opportunity to work remotely, that there was no opportunity other than to make sure that we acknowledge, and we did that through the retention pay and, obviously, with the personal support workers, keeping that $3-per-hour wage in effect.

The Chair (Ms. Goldie Ghamari): Five minutes left.

Mr. Adil Shamji: Thank you. In your estimation, has the $5,000 incentive been effective in retaining nurses?

Hon. Sylvia Jones: It's a difficult question to answer, because we don't know what would have happened if it had not been in place, so I'll just leave it at that.

Mr. Adil Shamji: Okay. Let's turn to temporary, for-profit nursing agencies now. Do you know approximately how much our health care system is spending on nurses through these agencies?

Hon. Sylvia Jones: The numbers that I am seeing are that 3% to 5% of nurses in the province are in what we would call temp agencies. But Dr. Zahn, did you want to dig further into that?

Dr. Catherine Zahn: Thank you, Minister. The minister has outlined some of the incentives that have been undertaken, and I think it's important to mention the number: 375,000 front-line workers are receiving or have received pandemic pay; only 225,000 of those are in the health sector, so it is much more broad. Our pandemic pay was one of the largest in the country, and since October 2020, we've invested over $1.3 billion for a temporary wage enhancement specifically for the PSWs.

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We have a number of initiatives on the go to stabilize, to advance the size of the workforce, and that includes opportunities—this has already been mentioned—to increase the numbers of internationally educated workers, in an ethical way, to bring them into Ontario. Also, there's a lot of work being done with our HR division, led by our chief nursing officer, to explore a variety of models of care that bring the whole team forward to care for patients in this stretched time.

I think it's fair to say that everyone is exhausted. Nurses are exhausted and beleaguered by the fact that there is no end in sight. There are—

Mr. Adil Shamji: Respectfully, Dr. Zahn, the question is, how much are we spending on temporary for-profit nursing agencies?

Dr. Catherine Zahn: I'm going to pass that over to the director of HR, David Lamb.

Mr. David Lamb: I'm David Lamb, director, capacity and health workforce planning branch, nursing and professional practice division at the Ministry of Health.

The overall cost for agency usage across the province is estimated in 2021-22 at $600 million. It's important to note that, from a hospital perspective, something in the region of 1% of total nursing hours worked belongs to agencies.

Mr. Adil Shamji: Are you able to comment on what the equivalent cost would be through the public health care system if it was paid directly by the hospital to employed nurses?

Mr. David Lamb: I don't want to give you a wrong answer on that, so we'll have a look and see what we can manage there for you.

Mr. Adil Shamji: I can respect that.

Minister, the FAO projected that this year alone the Ministry of Health will underinvest by $2.3 billion in our health care system. What do you say to that?

Hon. Sylvia Jones: Well, I think there are a lot of pieces that can be unwrapped with the FAO findings.

The Chair (Ms. Goldie Ghamari): One minute left.

Hon. Sylvia Jones: Thank you. First of all, we're not at the end of our fiscal. So there are going to be investments that hospitals, in particular, will make on the capital side that they have not done as of yet but will do by the end of the fiscal. This—

Mr. Adil Shamji: Should those not be here, though?

Hon. Sylvia Jones: No. My understanding—and Deputy Zahn, correct me—is that the funds flow when the commitment is made and the money is spent.

In capital, in particular—there have been some hospital corps who have decided, for any number of reasons, to delay, hold off, or end up having to push back their capital plans expansion.

In some cases, we have offered money and incentives for hospitals to do certain programs and, to your point, if they cannot find sufficient health human resources to do those programs—they may have suggested they could do X, but they end up doing 10% or 20% less because of the timeline.

The Chair (Ms. Goldie Ghamari): That's all the time we have for this round.

We'll now turn to the government. MPP Quinn, you may begin. You have 20 minutes.

Mr. Nolan Quinn: Minister, our government has made some significant new investments in mental health and addictions to support the people of Ontario. It has been a priority for our government from the start.

Several reports from experts are making it clear that the pandemic has led to more people experiencing issues in mental health and addictions. We see it in our communities daily. I see it at my business, with my teenage staff. My wife, who is a teacher, sees it as well. I see it with my friends and family.

In my riding of Stormont–Dundas–South Glengarry, we're delighted by the addition of six safe beds—the announcement this past summer at the Cornwall Community Hospital—which have been well received by local health professionals.

Can you please tell us more about the work we are doing and our plan to strengthen the mental health and addictions systems in the province?

Hon. Sylvia Jones: Of course. Our government is greatly concerned about the rising difficulties Ontarians are facing when it comes to mental health and addictions issues, especially in the wake of the pandemic.

The Canadian Institute for Health Information reports that between 2019-20 and 2021-22, there was a 72% increase in the number of children and youth coming to Ontario emergency departments with eating disorder concerns. The Office of the Chief Coroner of Ontario reports that between June 2019 and June 2022, there was an 80% increase in opioid-related deaths in Ontario. And 58.9% of Ontario's students in grades 7 to 12 feel depressed about the future because of COVID.

Well before COVID-19, improving Ontarians' access to high-quality mental health and addictions services was a priority for our government. In 2020, we released the Roadmap to Wellness, our plan to build a world-class mental health and addictions system. Supported by a commitment to invest an additional $3.8 billion over 10 years, the roadmap has added capacity to meet demand, fill critical gaps in the care continuum and start to build a provincial infrastructure that connects community, primary and acute care together to wrap around the needs of their common clients.

Between 2019-20 and 2021-22, our government announced $525 million in new annualized funding for mental health and addiction services and supports, funding focused mainly on community-based services such as child and youth mental health, addictions treatment, mental health and justice, supportive housing and Indigenous services and supports. In addition to investing in front-line services, our government has started to build the infrastructure to support a modern, high-performing service system.

Our first major step in this direction was standing up, in early 2020, the Mental Health and Addictions Centre of Excellence within Ontario Health. Proclaimed in legislation in February 2020, the centre of excellence has been tasked with leading the implementation of the roadmap on the ground. This includes developing clinical, quality and service standards, developing metrics related to systems performance and providing resources and supports to health service providers, bringing to the mental health and addictions systems the same credence and quality approaches of other major system transformations, such as cancer care.

I would now like to turn to Minister Tibollo, who will share some details of this important work we are doing to build system capacity.

Hon. Michael A. Tibollo: Thank you, Minister.

As Minister Jones stated, the Roadmap to Wellness, which was put into effect in March 2020, is the foundational document to basically set out what we're doing specifically to the various groups within our society or in our community. So we focus on children and youth, we focus on adults, we focus on seniors. We focus on establishing a continuum of care for each of those various groups, and we focus on ensuring that we're delivering culturally sensitive services. What that means is that services are being provided to individuals where and when those services are needed. They're regionalized so that individuals do get the supports close to home, because we know that the outcomes are much better and the recidivism rates are much lower when individuals are receiving those supports and services within their communities.

That is the basis of how the roadmap development was established. It's funded with $525 million of annualized funding, and it focuses on each of those different groups: for instance, the children and youth sector, the youth wellness hubs, providing a culturally safe space for individuals to be able to get supports they need—expanding services within those units from 22 to, by the end of this year, 26 additional, so we have 28 of them. The focus of those is to provide supports and services for everything, from eating disorders to first-episode anxiety and depression, and providing additional services as we expand. In addition to that, culturally safe services is a way of providing supports to Indigenous groups, again close to home—and in one particular case, a unit that's focused on Indigenous-led, land-based healing to provide supports for children and youth in Indigenous communities and to be further expanded as well. In addition to the Indigenous-led, land-based healing models and investments in the north, to ensure that the investments are being made when and where they're needed.

In addition to the $525 million, there is a $90-million one-time investment over three years focused on creating additional treatment beds for individuals throughout the province, and of that fund, 54% of those beds are focused on northern Ontario. Why? Because, again, when you look at the hot spots where we've had the highest incidences of overdoses and issues with respect to mental health, we know that those are areas that have been traditionally underserviced, and we wanted to ensure that enough services were in place to help individuals in the north. This, I believe, will as well be very helpful in dealing with some of the other issues, such as homelessness, given the fact that many people migrate to where they can find services.

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In addition to that, knowing that one of the social determinants of health is housing, our government, through both the Ministry of Municipal Affairs and Housing and the Ministry of Health, has made significant investments in the continuum of care to ensure that there is housing available to individuals that are in need of supports. Because we find and we know that individuals who do not have that support where and when they need it will repeat the process. Again, that isn't what is in the best interests of individuals, and we want to ensure that those supports and services are there.

In addition to that, we are investing in structured psychotherapy as part of our plan for the province of Ontario to ensure that anyone that needs cognitive behavioural therapy supports or other supports are able to also obtain that support when and where that's needed. Again, our intention is to ensure that the supports and services are there for individuals wherever they are in the province and however those services are needed.

The Chair (Ms. Goldie Ghamari): Next question? MPP Martin.

Mrs. Robin Martin: Thanks, Minister. You talked a bit about structured psychotherapy. I just wondered if you could you elaborate a bit on what that is.

Hon. Michael A. Tibollo: Sure. Structured psychotherapy right now is being rolled out through four different hospitals and will continue to spread throughout the province of Ontario. It's an initial investment of $20 million to provide structured psychotherapy.

Cognitive behaviour therapy is a form of talk therapy that's provided to individuals in need of assistance when they have anxiety or depression, primarily. Anxiety and depression can be mild, moderate or acute, and we've found that CBT is a modality of treatment that's very effective in those circumstances. It's modelled on the English model, with the experience that they had. It's an effective form of treatment, and in the past would have to be paid for privately by individuals. But our government implemented structured psychotherapy and is rolling it out throughout the province of Ontario for anyone in need of that support. There is self-referral, or the referrals can come through a medical doctor.

Mrs. Robin Martin: Can you just also elaborate, Minister—I know eating disorders have come up a lot, during COVID especially—on what we've done with respect to eating disorders, because that has obviously been something that's been very au courant right now.

Hon. Michael A. Tibollo: Thank you for that. Eating disorders and addictions have been something that have really plagued us forever, but, given COVID-19 and the isolation, what we've found is that, with young people especially—and, unfortunately, mostly with young girls—the only thing that really they can control in their lives is when and if they eat, and it's become, unfortunately, substantially more of a problem today. Unfortunately, it's not well-recognized by parents or even teachers or people that would have care and control of the youth. As a result of that, it usually goes unseen until that individual ends up in some kind of physiological distress and in an emergency room.

This came to our attention, and what we did was made investments and create a centre of excellence—investments totalling, I believe, $19 million—in the hope of creating a continuum of care with supports upstream, so that we have young people having access to nurse practitioners, social workers, education and prevention, so that we can hopefully prevent some of these more acute cases coming to hospitals.

So our investments have been tailored to that. There's still a great deal of work to do in that area, and we are looking, for instance, to roll them out into youth wellness hubs—so, again, culturally safe, low-barrier access point, which is really what we need for all mental health care supports. We're doing, as a government, everything we can to ensure that those low-barrier access points are available to our children, our seniors and everyone else that is looking for or needs that support, so that we can do away with that stigma associated with mental health issues.

Hon. Sylvia Jones: And, if I may, as recently as two weeks ago, I was talking to the CEO of the Ottawa Hospital, and they were thanking the government for their investments specifically related to eating disorder beds, and acknowledging that that has very much assisted the community.

The Chair (Ms. Goldie Ghamari): MPP Barnes?

Ms. Patrice Barnes: Thank you, Minister. I was actually going to ask a question around that, in regard to the implementation in March 2020. What are the successes we've seen since that implementation?

Hon. Michael A. Tibollo: How long do I have?

Ms. Patrice Barnes: Just the effectiveness that we've seen over the last—

Hon. Michael A. Tibollo: If I may, Minister? If I can say, I am very pleased with the progress we are making. I know that I can still criticize myself and say I wish that we could do more, faster, but it also is a challenge, because the same way we face HHR issues with health, we face them with mental health. It's great to open up 400 new beds through the Addictions Recovery Fund; that's 7,000 treatment spots. Where do we get the people to support those?

One specific investment we have made is with Canadore College, in creating a centre that will allow for the

training of Indigenous and non-Indigenous individuals as nurses, as social workers, as addictions recovery specialists. We're talking with NOSM to ensure that we're aligned in terms of what we're doing with respect to the creation of addiction doctors that focus on addictions, as well as working with psychiatric hospitals to look at innovative ways to bring supervision of psychiatric residences to the north, supervised remotely through the four psychiatric hospitals and any other hospitals that will join.

We're making progress, but two and a half years of COVID have not really been helpful for us, although it has led to incredible innovation. The virtual care that's being provided, whether it's through primary care mental health, whether it's through counselling or innovative virtual programs to assist—these are all things that we've learned about, and are extremely important in building that continuum of care where we have less acute cases.

So we're moving in the right direction. We're investing $525 million in annualized funding, which is giving us the ability to expand the supports and services on a regional basis, working with the Ontario health teams to ensure that we have those continuums of care and people get the care where they live, as opposed to having to migrate to another city and creating all kinds of other social issues.

The piece that still needs more work—it all needs more work, but the one piece that is a focus for us is working with the Ministry of Municipal Affairs and Housing to ensure that the continuum of care continues into providing supportive housing, or housing basically to allow individuals to break that cycle that seems to repeat itself and impacts the health care system dramatically because of the extra usage of emergency rooms and really using other supports that wouldn't necessarily be necessary if that continuum of care was adequate to support the individuals.

The Chair (Ms. Goldie Ghamari): MPP Wai? There are five minutes left.

Mrs. Daisy Wai: Minister, I know that our government is making major investments to build new hospital capacity across the province. In Richmond Hill, we see the benefits of it. Construction is under way, as well as the planning phases of dozens of major projects. I also understand that we provide support for community-based health care providers as well, many of which will help alleviate the pressure on hospitals.

As the parliamentary assistant for the Ministry for Seniors, I really care and am concerned about the seniors. Can the minister tell us more about how the government is investing in health care infrastructure to ensure Ontario has the long-term health care capacity that we need?

Hon. Sylvia Jones: Absolutely. Thank you for your important question. Investing in hospital infrastructure meets several critical areas of need related to growth, demand for services, critical infrastructure deficiencies and bringing care closer to home for patients. Ontario is committed to its comprehensive plan to build a health care system that puts patients first. As outlined in the 2022 budget, the ministry's plan will lead to investments of over $40 billion in health infrastructure over the next 10 years.

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The Ministry of Health is planning on expanding hospital capacity by approximately 3,000 beds over the next 10 years while also addressing significant facility condition deficiencies and rebuilding hospitals in a poor state of repair. The COVID-19 pandemic has changed community's expectations regarding health care infrastructure. The government continues to be committed to ending hallway health care and recognizes the importance of innovative solutions across the continuum of care to meet this commitment and build capacity in the system.

Given the fiscal realities facing the province of Ontario, investments made are fiscally responsible and efficiently addressing the most critical areas of need in Ontario. Investments made through the portfolio of approved capital projects over the next 10 years will result in capacity for approximately 3,000 new beds, and several of the larger projects in the plan will address key areas of demand growth across Ontario.

Hospital capacity creation is not the only solution for capacity challenges. All opportunities for creating capacity more efficiently or at lower cost will be explored to ensure that our investments are made where they are needed most.

Deputy, will you provide further details on our investments and the importance of health care infrastructure?

Dr. Catherine Zahn: As the minister has outlined, we have a 10-year capital plan that has a sum of $40 billion attached to it, and that is for ongoing new build. But as you would all appreciate, in the interim, there are existing structures in the health care system that age and deteriorate, so we have a parallel stream of ongoing major maintenance and repair. In partnership with our systems stakeholders, we're planning these investments over the short, medium and long term.

I have Associate Deputy Minister Peter Kaftarian here with us to elaborate on that and answer any specific questions that you may have.

Mr. Peter Kaftarian: Peter Kaftarian, associate deputy minister of clinical care and delivery at the Ministry of Health. Good morning, members.

By making investments in the right mix of services to best address the individual needs for health services in local communities, the Ministry of Health is committed to ending hallway health care and ensuring that the appropriate mix of services, such as mental health care, is available to Ontarians when and where they need it.

Effective capacity planning will address immediate system needs, support long-term sustainability through health system transformation and ensure care is available when and where it's needed.

In recognition of the need to make investments in the hospital system, the Ministry of Health is expanding hospital capacity by approximately 3,000 beds in the next 10 years.

The Chair (Ms. Goldie Ghamari): One minute left.

Mr. Peter Kaftarian: The ministry's plan to realize $40 billion in health infrastructure investments over the next 10 years will create new community infrastructure

such as primary health care centres, hospices and mental health and addictions treatment centres to ensure patients receive the right care in the right place.

Demand for major hospital investments remains at an all-time high. As the population of Ontario continues to grow old, our facilities continue to age and deteriorate, and there is a demonstrable need for capital investments for both new capital projects as well as investments to maintain and repair existing facilities. The intent is to balance growth, which would be considered new capital infrastructure to meet increasing demand, and renewal, which is maintaining existing facilities in good repair. The ministry is committed to making capital investments based on sound fiscal planning to ensure the investments are carried out efficiently.

The government of Ontario, through the Ministry of Health, provides guidance and support to health service providers across the province to build, renovate and maintain their health care facilities. To this end—

The Chair (Ms. Goldie Ghamari): Thank you very much. That concludes this round of questioning.

Seeing as the time is almost 10:15 a.m., I think this is a good place to recess—unless you would like to start now and I cut you off in about 30 seconds.

M^me^ France Gélinas: No. I just had a quick question as to—remember I had asked about the discretionary fund? They said $7 million for this year. I've asked for previous years. I just wanted to make sure that this is one of the questions that will be written for follow-up.

The Chair (Ms. Goldie Ghamari): All right. Thank you.

The time being 10:15 a.m., we will now recess until 1 p.m. Thank you, everyone.

The committee recessed from 1014 to 1300.

The Chair (Ms. Goldie Ghamari): Good afternoon, everyone. We will resume consideration of vote 1401 of the estimates of the Ministry of Health. There is now a total of one hour and 50 minutes remaining for the review of these estimates.

When the committee recessed this morning, the government had just finished their rotation. We will now go to the official opposition for their questions.

MPP Gates, you may begin. You have 20 minutes.

Mr. Wayne Gates: To the minister: In 2014, the Niagara Falls hospital was announced during my by-election and Niagara Health received a planning grant of $27 million. Our community has been anxiously awaiting this project and the community has worked hard to raise additional funds.

Just over a year ago, Niagara Health moved the project from stage 2 to stage 3. The inclusion of Infrastructure Ontario was a promising sign that this project was going to get shovels in the ground sooner. But here we are today. I'm still worried about the pace of construction of this hospital. We should have shovels in the ground this fall. There was a commitment that that was going to happen and it's been pushed back now until—well, the shovels may be around but the construction is not scheduled for another year.

Could the minister explain the unnecessary delays taking place in the construction of the Niagara Falls hospital and why the timeline continues to get moved further and further back? I'll have another part of the question as well.

Hon. Sylvia Jones: There is no doubt that there are many of us who are very excited about the investment being made in the Niagara region, but I will turn it over to Peter Kaftarian, ADM, to get into more details on the timeline.

Mr. Peter Kaftarian: Thank you for the question. Within my portfolio, that capital program does exist. We've been working very closely with the hospital and Infrastructure Ontario. As recently as last week we were in a meeting with the CEO and other members of the team.

The procurement is almost complete. It is likely to be the next project that is ready to award the actual contract, and I believe shovels in the ground are targeted right now for June 2023. I was just trying to pull up what the Infrastructure Ontario website says—if there's a date—but that's the latest information we have, which may be a little later than what had been originally anticipated, but the entire construction industry has been challenged in the last couple of years.

I just think that this is a really important project for the community and it's on a path to move forward.

Mr. Wayne Gates: I certainly do appreciate the response, but the reality is that the tradespeople in Niagara have been waiting for this project for a long, long time.

Is it fair to say that taking 15 years to build a hospital is what we should be doing in the province of Ontario? Should there not be a better mechanism in place? You announced Windsor this morning. You mentioned Windsor. Well, they're just starting their planning grant of $2.7 million. So from today until it's actually built—if they get the same kind of size as Niagara, and they're a little bigger than us so they may—15 years.

As we know, since 2014, health care has changed immensely in that time. I don't think it's fair, I don't think it's reasonable, and I don't think any community, particularly Niagara, which is growing in leaps and bounds, including in Sam's area, without saying his name—all that area is growing. So why is it that it's taken us 15 years from the time that it's announced, in 2014, until they're actually going to have the hospital built in Niagara?

The last thing I want to say—because I know the minister would know this—we closed five hospitals in Niagara to accommodate a new Niagara Falls hospital. We closed the Hotel Dieu, St. Catharines General, Niagara-on-the-Lake and Fort Erie. We cut services in Welland and we cut services in Port Colborne, saying, "Well, we're going to get this hospital." That was in 2014. And here we are; you're now saying shovels are going in in June, and that's what I heard, but construction won't start until the fall, which is really kind of surprising.

Please, I'd like you to answer that. If we're going to build hospitals, if you're going to do that and you're going to continue to announce it, we have to tidy up that timeline. You should not have to wait 15 years from 2014 till the time it's built. It's a mistake in the province of Ontario.

We need health care, we need new hospitals, we need other things around health care as well, but this hospital makes no sense to me.

I will finish by saying, because I don't want to take all our time, that doctors are coming to me and saying, "You've got to raise this issue. You've got to highlight this," that they are really, really concerned about health care in Niagara.

I appreciate the time. Thank you.

Hon. Sylvia Jones: I think, respectfully, you've answered part of your own question. Hospitals, when we build them, are built for 50-, 75-year lifespans. The amount of work and collaboration that has happened in the entire region to make sure that we are not doing a standalone that will assist one community and, in fact, hurt another—is exactly why we have the plan and the points along to make sure that we are looking at the region as a region.

The suggestion that we are taking away from other communities so that we could get a new hospital is, frankly, not accurate. We've built capacity within the entire system—and, I might add, not just a hospital system. You would know very well that we've also made investments in the Niagara region on the hospice piece, because we understand this concept of—from diagnosis through treatment and, ultimately, palliative, it's important to make sure that the capacity is there in the entire community.

ADM Kaftarian, do you want to add anything further?

Mr. Peter Kaftarian: I don't have anything else to add to that, Minister, unless there's a follow-up.

Mr. Wayne Gates: It is accurate. We have closed five hospitals and cut services immensely in Niagara on the idea that we're getting a new hospital. Any time I speak in here, it will be accurate. I've lived it for the last 10 years. We all want our new hospital built. We're working with all our partners in Niagara. We work with the regional council, city council. We're working with the CEO, Lynn, who does a great job in Niagara. We need the hospital. I guess my suggestion to the government—or any government—is that we have to find a way that doesn't take 15 years. That's my issue here. It's wrong. We can't wait any longer.

I appreciate you answering the question.

I'll turn it over to my colleague.

The Chair (Ms. Goldie Ghamari): MPP Gélinas.

M^me^ France Gélinas: I would like to follow up on a comment that the director of capacity and health workforce planning, David Lamb, made this morning: that $600 million was spent in 2021-22 for agency nursing, and that represented 1% of hours in our hospitals. I was just wondering if we have more details. Do we know if they were RNs or RPNs, and do we know which hospitals spent how much money?

Hon. Sylvia Jones: I'll let David get into more of the details, but I think it's important to understand that agency nursing is, by its very nature, used for ebbs and flows in the system. I'll use a very specific example: During COVID-19, we actually used—many of you would be familiar with the GO-VAXX bus. Those were agency nurses who were hired to go into communities that were at higher risk or had lower percentages—

M^me^ France Gélinas: Not in our community, Minister. We also had a bus in our community, and it was staffed by public health. They were not agency nurses.

I would rather get an answer to my question.

Hon. Sylvia Jones: I'm specifically using the GO-VAXX bus as an example of, as see increases and needs, that's really where agencies step up.

In long-term care as compared to hospitals, it would depend; some use no agency nurses, but some rely on them quite heavily.

Dr. Catherine Zahn: I believe, Madame Gélinas, that you might be referring to the fact that there is a great deal of variability across the province in terms of that agency use, and that between 1%, 3%, 5% variability is—first of all, it's just hospitals; the number is much higher in long-term care. And we do know that there are some remote and rural communities, in particular, that are very highly dependent on agency use.

Director David Lamb will be able to give you specific details.

Mr. David Lamb: Just to be clear on what the numbers are, the $600 million relates to all use of agency staff, not just nurses, in the entire province. What we know from the hospital side is that the number of hours worked by agency staff equates to approximately 1%—actually, slightly under 1% at about 0.7%. The agency usage in other sectors is higher, and we have some of the information that we can bring back in relation to that, but there will certainly be higher usage. To the point that the deputy minister made earlier on, there's variability across the province in where they're being used. There's a higher use in rural areas for sure.

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M^me^ France Gélinas: So where are those reports that—the $600 million. Could we have a breakdown as to which hospital reported how much money, and if it is for all staff? Do they also report that much money for RNs, that much money for RPNs? What kind of reports do you get and can you share that with us?

Mr. David Lamb: What we have is a more general rolled-up number associated with the hours worked by agency staff. Let's take that one back and we'll see what we can get.

M^me^ France Gélinas: Okay. And are those numbers up to date? Would you know if right now, in Ontario, is the use of agency nursing going up, going down, staying the same, shifting from long-term care predominantly to home care, to hospitals? Do we follow any of that?

Mr. David Lamb: We have some information, some slight comparisons between what exists today and what existed last year. The percentage associated with hospital usage is about the same. We also know, for example, that the number of agency nurses in Ontario—or those that, through the College of Nurses of Ontario data, report themselves as actually being agency nursing staff—has not changed very much from one year to another. It's something in the region of about 0.51%. But, again, we

can get you more information about that—I don't want to spout too much—and make sure we're accurate. That just gives you a bit of a general sense at least from the hospital perspective.

M^me^ France Gélinas: Okay, I appreciate that. Would you, in your position, also see not only the percentage used in hospital but know what the percentage used in long-term care is?

Mr. David Lamb: We have some sense of that, yes, and we can work with our long-term-care colleagues to ensure that you get the accurate numbers.

M^me^ France Gélinas: Does the same apply to home care?

Mr. David Lamb: The way in which home care is organized is slightly different. I'd have to get back to you on that one.

M^me^ France Gélinas: I would appreciate that. Thank you.

My next series of questions would have to do with nurses. Do we keep track as to how much overtime hours have been worked by nurses, let's say, in the last fiscal year? And do we know this by sector, like how much overtime was worked in our hospitals? Let's start with that.

Mr. David Lamb: The amount of overtime that's worked within a hospital is really the preserve of the hospital. It's part of their preserve under the PHA to manage those hours. So we can get reports of that, but I don't have any data to give you at this time.

M^me^ France Gélinas: So it's something that you could gain access to, but you don't collect this on an ongoing basis. Is that what you're saying?

Mr. David Lamb: That's correct.

M^me^ France Gélinas: All right. We've also seen a bit of a shift from RNs to RPNs in different sectors, different wards in our hospitals. Do you keep track of this as to what nursing mix is being used? Are there best practices that the government has put out?

Mr. David Lamb: I'd say there are two things to the comment that you've made. Firstly, the government does keep track through our health professions database as to the number of RNs and the number of RPNs that report to the college on an annual basis as to where they work. So from our point of view, we do have and are able to put together a sense of—if a nurse is saying that they work in one and it's their primary place of employment, then we would have that information from there.

The second point, though, again goes back to the idea that, in relation to the work that's being done in different wards and different units of the hospital, it would be the responsibility of the hospital to ensure that they have the skill mix associated with that.

The other thing I think that's important to note is that when it comes to matters of professional practice, there are clearly questions around the knowledge, skill and judgment and the skill mix of nurses associated with how they would be providing their services. Some of that is the preserve of the College of Nurses of Ontario. But again, some of it is the preserve of our experts in the hospitals, who are working and understand the time and motions necessary and the skill mix required in order for them to be able to provide services on the unit. So that wouldn't be something that the government, per se, would be providing or suggesting best practices for.

Dr. Catherine Zahn: If I may? This is a very significant topic of conversation in the health human resources world, particularly in the nursing world. In Ontario, over decades, we have moved to a model that's actually a little bit unusual for North America, and certainly unusual for Europe, where we've been highly dependent on registered nurses—

The Chair (Ms. Goldie Ghamari): Five minutes.

Dr. Catherine Zahn: —and not as much towards RPNs or PSWs. It's now understood that the training of these other professions is sufficient for them to be operating at a much more expanded scope of practice, and we have some really good opportunities now to be creating, with colleges, the practice standards and models of care that could really amplify the impact of our current health human resources.

M^me^ France Gélinas: Switching gears a little bit: This morning, the minister talked about the new graduate nursing initiative and gave us the numbers. Do we know the total amount of money that was spent on the new graduate nursing initiative compared to years before? In northern Ontario years before, we saw them in every hospital; now very few. Is this just northern Ontario? Do we have the amount of money that the government spent on the new grad nursing initiative?

Hon. Sylvia Jones: Are you talking about the Learn and Stay program? Because that would be out of colleges and universities.

M^me^ France Gélinas: No, I'm talking about: You are guaranteed the first six months will be full-time. The hospitals apply, they have a new graduate nurse, and they can give them full-time work for six months.

Mr. David Lamb Thank you for that. We can come back with the number for that. What I can tell you is that on an annual basis, up until 2019, the Nursing Graduate Guarantee you referred to, which is a program effectively that provides that training but also some funding as well for professional development of staff within a hospital, in that they then can work for another 12 months, normally provides support for something in the region of 600 nurses. In 2020, though, and 2021, we've seen that increase significantly, and indeed this year alone, so far, we have provided support to 1,400 nurses. So through some of the increases that were made that will be discussed later, we've been able to increase the capacity of that, and we can come back with some numbers for you.

M^me^ France Gélinas: Do we have a breakdown as to where the nursing positions are? Can I find out who applied? Where are those 1,400 nurses?

Mr. David Lamb Yep, we can look in to that for you.

M^me^ France Gélinas: Okay, much appreciated.

The same thing with—and now I forgot the name of the program, but it was mature nurses, to retain them in the health care system, mainly in hospital. Hospitals were able

to tap into a little bit of money to retain experienced nurses to help mentor some of the new ones.

Again, I'm wondering as to where the money stands with this. How much money are we spending on this and how many nurses are we able to enrol into this program?

Mr. David Lamb: You are referring, I think, to the Late Career Nurse Initiative. The Late Career Nurse Initiate is not in service at this time, but through the announcement of the plan to stay open, the ministry is developing a mid- to late-career nursing initiative to take its place.

Mme France Gélinas: That will come in this fiscal year?

Mr. David Lamb: Yes.

Mme France Gélinas: And do we know how much money will be attached?

Mr. David Lamb: Not at this time.

Mme France Gélinas: Okay. Good enough.

How about the funding for the Community Commitment Program for Nurses? How much money are we talking? Is the program still going on? And who's getting that money?

Mr. David Lamb: Yes, the CCPN, as it's called, which effectively is a nursing return-of-service program, is running currently. The overall cost of the program over the course of the next four years will be $81 million. The program will be providing a total of 3,000 nurses over the course of the next two years, so this year and next year, with 1,500 spots being secured for rural locations.

The Chair (Ms. Goldie Ghamari): One minute left.

Mr. David Lamb: The reason why the funding is over four years is because it's effectively a return-of-service program, which means that the funding over the course of the next four years is paid to nurses in increments.

Mme France Gélinas: The nursing student extern program?

Mr. David Lamb: The nursing extern program has been running now since January 2021. The program itself, as it currently stands, the overall total of externs who have been supported is 4,719, and this year alone 945.

Mme France Gélinas: How much money?

Mr. David Lamb: I'll need to get back to you on that because there are several increments that we'll need to put in place, but we'll come back with a number for that.

Mme France Gélinas: Off the top of your head, are we investing more into this program year over year? Is it going up, down or staying the same?

Mr. David Lamb: The program has really only been in existence for about a year or so, but what I can tell you is that the program started out by servicing something in the region of 11 hospitals and now serves 60 of those hospitals, and the numbers, obviously, to support the externs—those are nurses and other health providers in training who would be able to provide services in hospitals. That funding has increased over the course of this year.

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Mme France Gélinas: Can I get that funding—

The Chair (Ms. Goldie Ghamari): Thank you. That's all the time we have for this round.

We'll turn to the independent member for 10 minutes. You may begin.

Mr. Adil Shamji: Minister Jones, I wonder if we could carry on where we left off, which is in regard to the projected $2.3-billion underinvestment in health care this year. I believe you were in the process of responding that those additional funds may be accounted for in future programs later this year, although what is projected to be spent should match what is here. I wonder if you can elaborate a little bit on that.

Hon. Sylvia Jones: Yes, I'm happy to. The examples I was giving was capital—so in some cases, perhaps as they go through the planning stage, the hospital corporation makes a determination that they want to modify the original plan, and they work with IO and the ministry capital division to make those changes. That might be an example of a delay of a project being bid and let out for tender.

Another example would be programs we've put in place that, for any number of reasons, including an inability of the hospital corporation to hire someone for that position, is unable to—so that would be another case where the funding has been set aside and committed but ultimately is not flowed in that fiscal year because the program wasn't up and running.

Dr. Catherine Zahn: Another piece of this is that it's quite typical for us to see this apparent lack of spending until the third quarter—usually, it isn't until the third quarter that we have a good assessment of what the year-end will be, and actually, there's some good to that. It's an opportunity to reallocate dollars into areas where they're more needed than in another area. There is also an artifact of the numbers that you get in terms of consolidated entities, which are most of the hospitals. The money is transferred there, but then it doesn't necessarily go out the door in a month-by-month fashion. So we actually have a much better view of the health spending at the end of Q3.

Peter may want to add some details to that.

Mr. Adil Shamji: In your remarks, if you would just address the fact—one thing that I'm still not understanding. This underinvestment is anticipated to grow, according to the FAO. I understand what you're saying about that, by the third quarter, there should be some sort of reconciliation or catch-up. But the FAO, just a few weeks ago, was projecting that there will be sustained underinvestment to the tune of—by 2028—I think $23.1 billion.

Dr. Catherine Zahn: I would say that the plan is for that not necessarily to happen, particularly if we have the opportunity to accelerate our HHR status improvement and catch up on surgeries.

I'll turn it over to Associate Deputy Minister Kaftarian to fill in the blanks.

Mr. Peter Kaftarian: We work very closely with the FAO when they're producing reports. But an example here—and I was trying to pull the report up—is, they're going to model based on a series of their own assumptions, and they're going to provide analysis based on what they see the spend plan for the government is compared to what they believe it should be. So each year, we go through a

planning process, and we take it forward for consideration for government investments in hospitals. For example, this year, there was just over $800 million in hospitals, funding for beds, funding for surgical recovery. The FAO report is a point-in-time analysis, so it's not necessarily going to align with what we've taken forward and had built into the fiscal plan.

Hon. Sylvia Jones: You heard earlier today about unsolicited proposals. The quantum of the unsolicited proposals that come in for either innovation or unexpected things that happen within our hospitals in particular—when there is an underspend in one area, it gives us an opportunity to redirect that to a more urgent emergent issue.

Mr. Adil Shamji: Okay. I think I'll take some questions back to the FAO, and I hope we can continue to have this line of communication open.

The Chair (Ms. Goldie Ghamari): Five minutes.

Mr. Adil Shamji: Can I ask you to elaborate on what looks like a substantial decrease in public health funding between 2021-22 and 2022-23? It seems to go from roughly $2 billion last year and decrease to $3.4 million this year.

Hon. Sylvia Jones: That decrease that you see would have all been related to COVID-19 costs that our public health units experienced during the height of the pandemic and, of course, the height of vaccines, where we had the mass immunization clinics etc.

I'll turn it over to ADM Blair.

Ms. Alison Blair: Hi, there. I'm Alison Blair. I'm associate deputy minister for health integration and partnerships.

The vast majority of that change is related to vaccine and testing, where the vaccine uptake after the initial surge—and we're now at over 35 million vaccines that have been provided. But the pace of that has been lower as uptake has slowed. We're hoping for a surge of boosters in the next little while as we prep for the fall. But that is a significant portion, and that expenditure is not just in public health units, although it does show up in the public health lines. It's also related to other channels, including the clinical assessment centres that are sometimes associated with hospitals, sometimes associated with primary care, so for testing and for vaccination, which includes public health and also pharmacies.

Mr. Adil Shamji: I hope you will forgive me for being blunt, but I'm quite underwhelmed by the vaccination campaign taking place this year, and I can't help but wonder it it's a reflection of this lower amount of investment. So if we want to get that up, are the funds set aside for that, and what measures are in place in order to address that as we go in to an extraordinarily difficult fall and respiratory season?

Hon. Sylvia Jones: We've done a number of things in partnership with our public health unit, but we've also done a public advertising campaign talking about making sure that you are up to date on all of your vaccines. As you know, as a result of very much focusing on the COVID vaccination process, we are playing a bit of catch-up with our childhood vaccines in particular. So when our government made the commitment to keep those 600 nurses, RNs that were hired within our school system, it is our hope that it will not only continue to assist in the COVID vaccines, but also catching up on childhood vaccines. That would be an example of where we are continuing to make those investments to ensure that people get the vaccine when they can.

Mr. Adil Shamji: Are there any plans to increase funding or to expand that vaccination campaign, or can we expect the vaccinations to continue along the same lacklustre trajectory?

Hon. Sylvia Jones: Well, I will say, and then I will turn it over to Deputy Zahn, that, in fact, we are seeing an uptake. In the fall, we were looking at approximately—we were tracking about 10,000 per day; we're now closer to 35,000 per day. So there are ebbs and flows, absolutely. ADM Blair made reference to it. We all think about it a little more when we're inside more often. We want to make sure that our schools remain open, remain safe. So those focuses on our most vulnerable will continue.

I will turn it over to Deputy Zahn.

Dr. Catherine Zahn: Just to be clear, there is excess capacity to provide the vaccines; there is not uptake. I think, to your point, we need more public-facing information to accelerate that. As you heard, that is partially under way, through public health and other mechanisms, to increase awareness in the need for vaccine.

The Chair (Ms. Goldie Ghamari): One minute.

Mr. Adil Shamji: Just as an aside, I must admit, as I drive in to work, I hear more ads complaining about the lack of federal health transfers than I do about increasing immunization. So I hope that the ministry and the public health units will be working on that.

I guess we can continue this question, then, and then explore the answer further. I'd like to turn to the plans to address the surgical backlog. I know that some investments have been made, but unlike in other jurisdictions, those investments haven't been tied to annual targets for catch-up. I wonder if you can comment on why that is.

Hon. Sylvia Jones: We've actually put a lot of flexibility in the plan. As hospitals bring forward how they can deal with their surgical backlog, we've already seen, in diagnostic in particular, that we've basically wiped out the backlog to pre-pandemic levels. Obviously, as we deal with RSV and our pediatric challenges, that does add another level of complexity.

1330

Deputy Dr. Zahn, did you want to expand on that?

The Chair (Ms. Goldie Ghamari): Thank you. That's all the time that we have for this round.

We'll now turn to the government. Who would like to begin? MPP Wai.

Mrs. Daisy Wai: I would like to say thank you to Mr. Peter Kaftarian. I thank you for your response this morning to my question on the investments we have made to the infrastructure for long-term care. I understand that with the time constraint, you might not have given us all the

information. Is there any more that you can share with us to elaborate on this topic?

Mr. Peter Kaftarian: A short answer would be yes, there's much more I'd like to share, and I'm happy to do that now.

Mrs. Daisy Wai: Thank you.

Mr. Peter Kaftarian: I think where I left off, we were talking about the government of Ontario, through the Ministry of Health, providing guidance to health service providers across the province to build, renovate and maintain existing health care facilities. To this end, we have a hospital capital planning and policy manual that establishes a policy framework for managing capital assets in the hospital sector and for setting out policies governing capital projects and processes, including approved capital funding, the document submission requirements for hospitals proposing to undertake a capital project, and the subsequent review and approval process carried out by Ontario Health and the ministry.

More specifically, the capital planning manual communicates the ministry's capital planning and approval processes, policies and guidelines for stakeholders. It clearly outlines the requirements to be compliant with the ministry and government policies to maintain legislative and fiscal accountability. It provides direction on how to effectively navigate the capital submission and review process, and facilitates the development of capital submissions that will foster the delivery of high-quality care through patient-centred design.

Hospital capital projects follow a cycle of identifying a need, developing a concept, creating a plan, implementing the plan, closing out the plan and monitoring ongoing operations. Success can be measured by the extent to which the capital project is completed on time and on budget, within a predefined scope, and able to meet the intended health service delivery needs in the community.

Planning is an ongoing and vital component of the health system, and, as such, hospitals and regional planning bodies are responsible to continuously monitor the needs of their communities. As part of the capital process, hospitals are required to develop and refresh master programs and master plans, which outline a hospital's comprehensive long-term plan and business case analysis for programs, facility and site within the health system context, to determine the needs of specific capital projects.

The ministry works closely with providers to appropriately plan, containing the projects' scope and managing projects within the approved budgets, through several approaches. First, planning grants: This is a provision of a small dollar amount, compared to the overall cost of the project, and it's a requirement to plan to a target number of beds or a certain cost level. We have service volume projections to estimate future bed needs, which require operational efficiencies to be embedded prior to building the new space.

Space standards: We target departmental and/or room sizes based on acuity levels, and we model model-of-care benchmarks and best-practice facility design, such as standardized room layouts.

I think I mentioned a little bit earlier that there are two main types of capital projects, and I'm going to give some examples shortly. First are renewal projects that are undertaken to restore, rehabilitate or replace an existing asset to its original capacity or performance capability. These types of projects are fundamentally carried out in order to extend the useful life of an existing building or building asset. Internal renovations that restore the functionality and/or condition of the existing space without increasing the physical footprint would be considered a renewal project. Renewal projects do not address facility maintenance, but include work above and beyond facility upkeep to improve clinical service delivery.

By contrast, expansion projects are designed to increase an organization's ability to deliver services by adding a new asset to an organization's system—for example, new clinical programs—or by increasing the physical capacity—such as the building footprint or adding floors—of an existing asset.

An example of an expansion could be adding a new building or wing to a hospital in order to accommodate demographic growth, new programs and services not previously offered at a given site, or an increase in demand for clinical services. It could also include renovating an existing space; for example, space made available through relocation of some services to adapt new or emerging models of care.

Regardless of the project type, all capital submissions must enter and navigate through a multi-stage process. The ministry has employed a streamlined, three-stage capital planning process to help move things along at a quicker pace. The ministry has recently, in partnership with stakeholders, streamlined the capital planning process to expedite investments, to ensure projects are delivered efficiently and cost-effectively.

Embedded within the capital planning process is the capital approval process. To proceed from one stage to another requires approval from the government and/or ministry, and the level of authority within the government or ministry at each stage depends on the classification of the project. For example, a large project over $20 million requires government approval to proceed to construction.

Over the last few years, since June 2018, we have nine major projects that have started construction, including the West Park Healthcare Centre redevelopment project, which will result in the construction of a new, six-storey facility that will provide increased capacity for in-patient ambulatory care, outreach diagnostic and therapeutic services, with a capacity of 314 beds upon opening. The brain sciences centre at Sunnybrook Health Sciences Centre in Toronto includes the construction of a new, three-storey building on the Bayview campus. The project will allow Sunnybrook to become a provincial resource for youth and adult mental health services, and a leader in brain science research.

More recently, there are three major projects that have started construction since the beginning of 2021. First, the Markdale Hospital greenfield capital redevelopment project at Grey Bruce Health Services will replace a 64-year-

old deteriorating facility with a new building on a new site. It will have a 24-hour emergency department, a short-stay in-patient unit and clinical and laboratory services to preserve core health services in a rural region. Next, the Branson site Reactivation Care Centre at North York General Hospital will improve access to care for patients and families and reduce wait times in hospitals. This project will support 120 new transitional care beds for North York General Hospital and other hospitals who are facing capacity challenges, allowing patients with lower-acuity needs and alternate-level-of-care patients to be relocated to the site. And the last project on this list, the West Lincoln Memorial Hospital project in Grimsby, will result in the construction of a new hospital on an existing site to replace the existing facility. Sixty-one beds will be built, along with modern emergency, surgical and obstetrics facilities.

Throughout the COVID-19 pandemic, the ministry has responded to and addressed significant challenges in the construction market in partnership with Infrastructure Ontario, the province's agency. Rising inflationary pressures, supply chain disruptions and labour market availability have led to rising cost pressures across all construction sectors. In response, the ministry and Infrastructure Ontario have aggressively engaged with the construction market and health service providers to receive feedback and ensure investments are targeted to health system priorities and carried out efficiently.

The resulting innovative procurement approaches have allowed the ministry to remain on track with its investment plan and to achieve significant procurement milestones over the past year for projects, including the Niagara health system's new south Niagara project in Niagara Falls, which proceeded to a request for proposals, or RFP, in October 2021, and closed in August 2022. This new greenfield hospital will replace several outdated existing facilities and significantly expand hospital capacity across the Niagara region.

The Weeneebayko Area Health Authority—or WAHA—redevelopment project will result in the construction of a new health campus in Moosonee, including a new hospital, elder care lodge, mental health and addictions services, and federally funded hostel and accommodations, as well as a new ambulatory centre in Moose Factory. On October 31, 2022, the development phase RFP closed, which will allow the province to bring on board a construction industry development partner, targeted in January 2023, to finalize the project design. The innovative approach to project planning will allow WAHA and the province to work collaboratively with a construction industry partner to develop approaches to building a northern and remote environment.

The Trillium Health Partners Queensway site request for proposals was released in September 2022. This project will result in the construction of a new in-patient tower to consolidate and expand complex continuing care and rehabilitation services for patients.

The Centre for Addiction and Mental Health phase 1D project achieved request for qualification release in February 2022. This project will result in a complete rebuild of the forensic mental health unit at CAMH—

The Chair (Ms. Goldie Ghamari): My apologies. Let me pause this for a moment. As there is a division being called in the House, pursuant to standing order 131, I must suspend the committee meeting at this time to enable members to make their way up to the chamber to vote.

I ask members to please return promptly, as the committee meeting will resume shortly after the vote in the House. Thank you.

The committee recessed from 1341 to 1353.

The Chair (Ms. Goldie Ghamari): Good afternoon, everyone. We will resume consideration of vote 1401 of the estimates of the Ministry of Health. There is now a total of one hour and nine minutes remaining for the review of these estimates.

When the committee recessed this afternoon, the government had nine minutes and 40 seconds remaining, and so we'll now resume. Thank you very much.

Mr. Peter Kaftarian: I'll continue with my overview on the capital. I was talking about different projects. The next one I think I started with was CAMH, Phase 1D. This project achieved request-for-qualifications release in February 2022, and the project will result in the complete rebuilt of the forensic mental health unit at CAMH, along with significant investments in research and other community services.

The Trillium Health Partners' Mississauga hospital site project achieved close of the development phase and request for proposals in September 2022. The project will redevelop Trillium's Mississauga site and create hundreds of new beds, along with new surgical and emergency capacity to help address demand for additional hospital services through the Peel region.

These milestones are in addition to the 20 major hospital projects that have reached completion in the past several years, including the Mackenzie Health Cortellucci Vaughan Hospital that accommodates emergency services, surgical services and operating rooms, acute in-patient and intensive care beds, diagnostic imaging, and specialized ambulatory clinics. As a result, Mackenzie Health is now a two-site hospital system, with hospital services distributed between the Richmond Hill hospital and the new Vaughan hospital to ensure optimal efficiency and accessibility for people and their families.

The Centre for Addiction and Mental Health, CAMH, phase 1C involved the construction of two new buildings to provide modern facilities for in-patient beds, ambulatory programs, and relocation of the emergency department and emergency access unit to the Queen Street site. The new buildings will also accommodate the centre for discovery and knowledge exchange, supporting research and education.

The Etobicoke General Hospital phase 1 patient tower at William Osler Health System in Etobicoke involved the construction of a new four-storey tower, adding approximately 250,000 square feet of space to the existing facility. The new tower accommodates an emergency department, critical care services, a portion of maternal child services,

and various ambulatory and support services. This phase also included the construction of a new entrance, a number of infrastructure upgrades to the existing facility, and interconnectivity demarcation points from the existing facility to the new tower.

The Bickle Centre infrastructure upgrades project at the University Health Network was completed in April 2020 and addressed a range of patient safety, infection control and accessibility issues, in addition to mould remediation, upgrades to infrastructure systems, and refreshed patient areas. The associated dialysis project at the Bickle Centre also saw the conversion of an in-patient unit to accommodate a dedicated 12-station dialysis suite in order to provide extended overnight hemodialysis on-site in the 208-bed complex continuing care hospital.

The electrical switchgear replacement project at Michael Garron Hospital in Toronto was completed as an enabling works project, as part of the hospital's phase 1 new patient care tower project currently under construction. The main redevelopment project required enabling works to improve the hospital's base infrastructure by upgrading the electrical distribution infrastructure in order to facilitate the construction of this future health care facility addition.

The cardiac life support services redevelopment involved the construction of a new tower and renovations to the existing University of Ottawa Heart Institute facility, which is located on the Civic campus of the Ottawa Hospital. The project increased the institute's capacity to accommodate needs resulting from shifting demographics and technological advancements, and expanded and improved access to high-quality specialized cardiac services for resident in the region. The project achieved substantial completion in January 2020.

The mental health/complex continuing care/rehab project at Brockville General Hospital in Brockville involved the construction of a four-storey tower, plus penthouse, adjacent to the existing hospital that accommodates 93 new in-patient units for complex continuing care, acute mental health, rehabilitation, including 22 net new beds and other selected programs. The project achieved substantial completion in August 2020.

The Chair (Ms. Goldie Ghamari): Five minutes left.

Mr. Peter Kaftarian: Thank you.

The redevelopment of l'Hôpital général de Hawkesbury/Hawkesbury and District General Hospital in Hawkesbury involved a combination of new construction and renovations. The redevelopment project has increased the hospital's capacity by close to 50% to better serve the Prescott-Russell community. The project has provided for larger, brighter and more comfortable facilities with leading-edge technology and equipment and more specialized medical care closer to home, for a family- and patient-centred bilingual community hospital with a regional focus. The project achieved substantial completion in December 2020.

And the last project on the list for today: The replacement hospital at Groves Memorial Community Hospital is a new community hospital located at a greenfield site located between the towns of Fergus and Elora in Wellington county. The new 45-bed hospital replaces the Groves aging site in Fergus. Patients were moved to the new hospital in August 2020. The new hospital includes medical, surgical, obstetrics, specialized care and complex continuing care beds and provides emergency and ambulatory care facilities. The hospital also includes improved facilities to accommodate medical students and learners.

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To address the increase in demand for health care services from a growing aging population, Ontario continues to advance planning for a record investment in expansion and renewal of hospitals that provide essential care to patients and their families, including a new in-patient tower at William Osler's Peel Memorial site and ongoing planning of a new regional hospital in Windsor-Essex. The government is also investing in the creation of a new children's treatment centre in Ottawa to increase access to critical programs and services.

I'm going to talk a little bit about community-based health infrastructure investments now. Of course, health care is not only confined to the hospital setting. The ministry continues to make effective investments across the community sector to progress towards an integrated system where patient care is delivered in the right settings.

Hospices: The ministry is supporting new hospices across Ontario by contributing to the costs in construction and renovating new and existing facilities. To date, the ministry's hospice capital program has committed capital funding for 27 residential hospice projects, creating 198 beds—102 beds have completed construction to date and are located across the communities in Toronto, Vaughan, Halton, Durham, Northumberland county, Bay of Quinte, Simcoe county, Perth county, Waterloo, Windsor, Nipissing and Sudbury. The remaining 96 beds are yet to be built but are expected to complete construction over the next two to three years in communities such as Toronto, Niagara, Perth county, Grey county, Elgin county, Kingston and Dryden.

Reactivation care centres that I've mentioned a few times: The ministry has funded 478 transitional care beds in reactivation care centres at Humber River Hospital's Church and Finch sites, North York General's Branson site, Sunnybrook's Pine Villa and Providence Care in Kingston; 332 additional reactivation care beds are expected to open in the next two to three years from expanding on this successful model of care to health services in Sudbury, Southlake regional hospital, Oak Valley hospital, Unity Health Toronto, St. Joe's health centre Hamilton, Trillium Health Partners and North York General Hospital and Scarborough Health Network.

Consumption and treatment sites: The ministry has funded capital renovations for 14 consumption and treatment services located throughout Ontario, including Guelph, Hamilton, Kitchener, London, Ottawa, Thunder Bay and Toronto. Consumption and treatment services save lives by preventing drug overdose-related deaths and by connecting people to addictions treatment, mental health services, primary care and social services.

Aboriginal health care access centres, an Anishinaabe community health centre and other investments to support Indigenous communities are also under way.

The Chair (Ms. Goldie Ghamari): One minute.

Mr. Peter Kaftarian: In Toronto's West Don Lands neighbourhood, the Anishinaabe community health centre is currently under construction. This important project will consolidate and expand operations currently located in a number of different sites in downtown Toronto and create an important new community space.

This project is just one of nine Indigenous-focused community projects under way right now. Two additional projects include building a new facility for the Sioux Lookout First Nations Health Authority primary care team, serving the towns of Sioux Lookout and Pickle Lake. The new facility will house primary care and other allied health services for an integrated and holistic model of care to provide seamless delivery and address the many jurisdictional and service-delivery gaps that currently exist. The second item would be building a new facility for the Algonquins—

The Chair (Ms. Goldie Ghamari): Thank you very much. That's all the time that we have for this round.

We'll now turn to the official opposition. MPP Gélinas, you may begin.

M^me^ France Gélinas: Actually, if you wouldn't mind repeating: You said that you contribute to the cost of hospice palliative care beds, and you named all of this. Could you tell me what percentage of the cost of those builds do you contribute?

Hon. Sylvia Jones: If I may start, Chair: Because hospice model originates in community, it would very much depend on what the community and the funders and organizers are looking at. We standardize at the provincial level, but I will turn it back over to ADM Kaftarian.

Mr. Peter Kaftarian: I need to pull up that number; I believe it's a fixed amount per bed. I just don't have it at my fingertips.

M^me^ France Gélinas: Okay. I would like if you could share.

It's still about hospice. They were at Queen's Park two weeks ago. All of them are saying that the model where you only pay for the care but don't pay for the electricity and the water and the food and the food prep and all of this is really hard. They would like to see the operational costs of hospices go from the about 50% that they are at right now closer to 70% or 75%. Is this something that you would have the budget for? Do you know how much it would cost? And would you be open to that?

Hon. Sylvia Jones: There is definitely a desire within our government to expand the opportunities for hospice-based care in Ontario. We are doing it actively right now in Niagara. In fact, because of the unprecedented capital increase, we were able to fund them some additional because they were at the stage of letting the tender.

In terms of standardizing or increasing the per-bed—

M^me^ France Gélinas: Operational costs?

Hon. Sylvia Jones: Yes, the per diem costs. As you know, hospices play a very different role than hospitals, and we as a government and a ministry do not mandate what type of care and who provides that care. There is more work that would need to be done in terms of how we standardize it without taking out the uniqueness of, frankly, what makes hospice such an appealing model for end-of-life—

M^me^ France Gélinas: If I hear you well, Minister, you're saying that you would be open to increasing the per diem that goes to our hospices?

Hon. Sylvia Jones: What I am saying is that there is not a consistent standard of care and who provides that care. And that's okay because that is the nature of how hospice has grown organically in the province of Ontario. So more work would need to be done to ensure that what we love about hospice and that community base, that community engagement—

M^me^ France Gélinas: Yes, but I'm interested in the money.

Hon. Sylvia Jones: Aren't we all? We are looking at it, but it is a more detailed review and study that has to happen, because as I say, all hospices don't use RNs in their care continuum. All hospices don't have the same sized rooms—

M^me^ France Gélinas: But they all need to be fed and none of them have money—

The Chair (Ms. Goldie Ghamari): I'd just like to remind members to not speak over one another for the purposes of Hansard. It makes it difficult for Hansard to record. So if we can just maybe let the minister finish her response and then you can continue.

M^me^ France Gélinas: No, I'm good. I got what I wanted. I have a whole bunch of stuff, and it's my last 20 minutes.

My next one was independent health facilities: How do I find out how much money is given from the government to independent health facilities per facility? I would like to know a breakdown of funding for independent health facilities for the last three years. We have all seen that the number has gone up by $13 million, but I would like to know who it went to.

Hon. Sylvia Jones: Again, it depends, frankly, on the service that is being provided by the independent health facility. But I will turn that over to Deputy Zahn.

Dr. Catherine Zahn: There are different types of independent health facilities. The most common ones provide minor surgical procedures, and by far cataract procedures are one of the major ones—

M^me^ France Gélinas: I am fully aware. I know them inside and out. I know the names; I've gone on the websites. The part I'm missing is money. How much money do you give to each of the independent health facilities that you have on your website?

Dr. Catherine Zahn: Yes, I'm going to turn it over in one minute to ADM Dicerni to explain that, but there are a number of fee modalities. I'll leave it at that and pass it over to Patrick.

Mr. Patrick Dicerni: Thank you for the question. What I'll start with is giving you full-up aggregate-level numbers by way of, as Dr. Zahn had said and I'll go a little

bit deeper, two main categories of independent health facilities, one being facilities that bill fee-for-service to the government. Those are things, Madame Gélinas, in the realm of diagnostic radiology, ultrasound and nuclear medicine.

There is a separate category of independent health facilities that are funded globally under transfer payment agreements between the government and the provider. Those are things like insured plastic surgeries, ophthalmological procedures like cataracts, as the deputy mentioned, and minimally invasive gynecological procedures. In each of these categories for the 2021-22 fiscal year for our fee-for-service IHFs, they were funded at the rate of $438 million. For the transfer payment agreements, and those were the more interventional or surgical procedures, funding there was at $65.8million.

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M^me^ France Gélinas: Any way that I can see the breakdown as to who got what?

Mr. Patrick Dicerni: I'll have the take that back for you. What I have at my disposal here are sort of full-up provincial numbers, but we'll take that back and see if can't drill down for you below the provincial level numbers.

M^me^ France Gélinas: Do you have the full-up provincial numbers for the two previous years?

Mr. Patrick Dicerni: Yes. For the 2020-21 fiscal year, fee-for-service IHFs were funded at $446 million and our globally funded transfer payment IHFs were funded at $56 million. For the fiscal year prior to that, 2019-20, for our fee-for-service IHFs, those were funded at $435 million, and the globally funded TPA independent health facilities were funded at $51 million.

M^me^ France Gélinas: I very much look forward to seeing a breakdown per facility. That would be very much appreciated.

I'm sorry; I'm jumping all over the place, but I only have 20 minutes.

My next one has to do with family-managed care in home care: How much money have we spent, and is there any interest in increasing the amount of money that goes to family-managed care?

Hon. Sylvia Jones: As you would know, in our last budget in the spring, we committed $1 billion over three years the home-based community care. I will turn that over to ADM Blair.

Ms. Alison Blair: I'm going to invite my colleague who is available virtually, Amy Olmstead, to talk about the self-directed care, family-managed care response.

Ms. Amy Olmstead: Thank you very much for the question. Amy Olmstead, director of the home and community care branch in the strategic partnerships division.

The funding for family-managed home care comes out of the broader home care budget. There isn't a fixed allocation for family-managed home care. So the investment in home care, the year-over-year increase that we are seeing this year that the minister referenced, the $1-billion, three-year investment, a portion of that is able to go to family-managed home care. That is based on the interest of clients and their substitute decision-makers in participating in the program and in the ability of the Home and Community Care Support Services—sort of how quickly they can onboard those clients.

M^me^ France Gélinas: Okay, because I'm getting a really different answer at the local level, where they tell me that they haven't seen a money increase in family-managed care for many years. The wait-list is very long. The staff to work in those exist, and they blame you; they say that the ministry has not increased. So am I right in saying that the $1-billion increase would be—a percentage of this will go to family-managed care where it is needed and people will finally gain access?

Ms. Amy Olmstead: I am happy to follow up with Home and Community Care Support Services about that question. Yes, we're quite clear from the ministry's perspective that the funding increases for home care that flow to Home and Community Care Support Services are available for family-managed home care. So I'm happy, again, to follow up with Home and Community Care Support Services. They might be referencing, for example, their own internal capacity to onboard clients as quickly as they would like, but I'm certainly happy to check.

M^me^ France Gélinas: It's not a question of quickly; it's a question of three years on the wait-list and nobody has been added. So I would be interested in finding out how much money was spent on family-managed care, let's say, for the last two years, three years, if you're able to, and which of the HCCSS—whatever you want to call them, sorry; the old CCAC, the old LHIN—are getting for family-managed care, year over year, in the last three years.

Ms. Amy Olmstead: Okay. We will take that back and get back to you the amount of funding allocated by Home and Community Care Support Services for family-managed home care. We can also note how many clients are being served by that program.

M^me^ France Gélinas: That would be great. Thank you.

I'm sorry; I'm jumping again. The $2 pay premium for PSWs working in hospitals—not a day goes by that I don't get a complaint from a PSW who still hasn't got her $2 pay increase. Do you have any idea as to why it's taking so long?

Hon. Sylvia Jones: All the money was flowed to the 140-plus hospital corporations in September, I believe, so it should have been given to the staff who qualified for it.

Did you want to go into more detail, ADM Kaftarian?

Mr. Peter Kaftarian: That's correct; we did provide approval and flow the funding, per the minister's comments. I think some of the hospitals explained to us that they've had some challenges at the hospital level with being able to update payroll systems and some of the complexities of that. So the money has made it, but due to some of the pressures hospitals are under right now on day-to-day, some things have come back into the ministry identifying that PSWs haven't received it. They are eligible. They will be provided retroactively. Right now, it's with the hospitals to ensure that the money does flow.

M^me^ France Gélinas: When the money flows—is there a letter, an agreement, a change to the existing agreements that happens to show the extra money, and could I have access to that?

Hon. Sylvia Jones: It's in the legislation.

M^me^ France Gélinas: So how do I find out how much money is flowed to each hospital, specifically for the $2 for PSWs?

Hon. Sylvia Jones: So you're looking for each individual hospital corporation—how much money we flowed for the PSW $2—

M^me^ France Gélinas: You got it.

Mr. Peter Kaftarian: That is information that we can provide.

M^me^ France Gélinas: Thank you. I'm jumping all over the place again. Northern Health Travel Grant—with the high cost of travel, I have more and more constituents who are not able to make it to their appointments simply because the amount of money is not enough. They don't have enough money to put out the expenses and wait to be reimbursed.

Is there any way to think of an emergency fund where some who qualify for Northern Health Travel Grants could be paid upfront so that they have the money to pay for their bus pass to come to Toronto, so that they have the money to pay for the hotel, all of that?

Dr. Catherine Zahn: That's something we'll have to look into, in terms of the exact timing of the flow.

I wonder if Patrick Dicerni could answer that more specifically.

Hon. Sylvia Jones: While Patrick is coming up—we did make some changes to the Northern Health Travel Grant that ensured that people got their money, basically, immediately upon filing. Those were upgrades, improvements to the program that have ensured people who choose to set up a profile can get their money literally within days.

M^me^ France Gélinas: And it works good?

The Chair (Ms. Goldie Ghamari): Five minutes.

Mr. Patrick Dicerni: Just to add a little bit to the minister's last comments: Effective November 30, our Northern Health Travel Grant Program introduced a revised application form that allows clients the option to provide banking information up front to receive approved program payments via direct deposit, so that's obviously going to eliminate a lot of the time that was associated with that. Cheque payments remain a payment option for NHTG clients.

I hear your question with respect to what would represent a policy change to the program, which is paying up front on the basis of an approved travel. That's something that would be for the ministry and minister to consider. But to give you a sense right now, the 2022-23 allocation for the northern health travel grant is $48.2 million, and that serves around 150,000 Ontarians.

M^me^ France Gélinas: Given that the price of gas in my riding is over $2 a litre, do you have any idea when the money that you give for mileage could be changed, looked at, brought up?

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Mr. Patrick Dicerni: I'd be happy to take that back and discuss that within the ministry and for the minister's consideration, but right now, there is no active consideration around amending those rates.

M^me^ France Gélinas: Okay. Again—sorry; I'm jumping all over the place. The next one is pay equity for midwives. Is there anywhere I would see an increase in the pay of midwives? If we look at the estimates, they are too small of an amount; they're not in there. How much money is spent on midwifery and midwives? And are we looking at increasing their salaries so we become closer to pay equity?

Dr. Catherine Zahn: I will hand this over, as well, to ADM Dicerni.

Mr. Patrick Dicerni: With respect to midwifery, I think you will have an inability to see it rolled up at the level that the estimates in public accounts are rolled up at, but currently the ministry is engaged in negotiations with the AOM with respect to the wage parity or wage agreement. There is currently work still going on between the AOM and the ministry with respect to more details on wage parity. I'm happy to take that back and provide that.

M^me^ France Gélinas: Okay. Because they are still in court for pay equity, but you are also negotiating at this point?

Mr. Patrick Dicerni: That is correct.

M^me^ France Gélinas: Okay. So both of those are happening at the same time?

Mr. Patrick Dicerni: Correct.

M^me^ France Gélinas: Okay. My last four minutes will be a whole bunch of money questions again. How do I find out the base funding per hospital, the COVID-specific funding per hospital and all the other sources of funding per hospital, like the ambulance off-load delays, the nurses funding, the pay per performance, the emergency funding, the quality-based procedures, the new grads—when I look at a hospital budget, all of those are in. I'm trying to see which one is their base budget, which one is COVID-specific, which one is directed at—and the ones that I know the most are ambulance off-load delays, nurses funding, pay per performance, the quality-based procedures, new grad nursing funding etc. Could you give that to me per hospital?

The Chair (Ms. Goldie Ghamari): One minute left.

Hon. Sylvia Jones: I don't think so, and the reason I say that is because I was, over the lunch hour, just speaking to an individual who talked about how they had successfully received some funding for, in this particular case, a nurse off-load program to assist in their emergency departments, but they have yet to hire the position. So there will be many examples where the application has come in, where the approval has been given, but the program has not started for any number of reasons. I think it would be quite challenging, moving forward—and much easier, of course, as the fiscal completes—to give that detail.

M^me^ France Gélinas: No, I'm looking back. I'm looking at 2021; I'm not looking at this year. Let's start with

base funding per hospital. Can I get a breakdown of base funding per hospital?

Hon. Sylvia Jones: Well, I can tell you, for the small hospitals, that it was—you know what? I'm going to turn it over to the DM.

Dr. Catherine Zahn: The hospitals have multiple streams of funding.

Mme France Gélinas: I'm fully aware.

Dr. Catherine Zahn: I think what you're referring to—

The Chair (Ms. Goldie Ghamari): Thank you. That's all the time that we have for this round.

We'll now turn to the independent member for 10 minutes. You may begin.

Mr. Adil Shamji: Minister Jones, when we left off, we were just discussing the fact that investments have been committed to clear the diagnostic and surgical backlog without any sort of goals or targets, and you articulated that it permitted greater flexibility. I'm not sure if you finished your answer—or perhaps you have—but I wonder if you could elaborate a little bit on that.

Hon. Sylvia Jones: Okay. That was 40 minutes ago; I will do my best.

Mr. Adil Shamji: I appreciate that.

Hon. Sylvia Jones: So, yes, as a government we set aside and made investments to make sure that the surgical backlog that was as a result of asking our partners to pause on one part of their core business to focus on vaccine protection and vaccine rollout—I think when I referenced it I was talking about how, on the diagnostic side, we're actually very good, basically pre-pandemic. Then, as we look at the surgical backlog, I'm going to turn that over to the deputy, Dr. Zahn, if I may.

Dr. Catherine Zahn: I don't have at my fingertips the exact amount, but we have in fact, through Ontario Health, which will execute on this initiative, an overarching target that was set some weeks ago now. There's a percentage of delayed surgeries that are extra-long waits, so beyond the recommended time frame. We had set the target of March 31 to have those eliminated, and then we have found ourselves, again, in the HHR crisis, so that will be re-evaluated and we will be able to bring back a new target. That would be a goal of March 31, and then we would set up targets, either monthly or quarterly.

Mr. Adil Shamji: Are those targets publicly available anywhere? I'll just elaborate a little bit. As I try to assess the suitability of the amount of investment that has been set aside for clearing the surgical backlog—the last number I heard was that this government is investing an additional $300 million. An additional $300 million could be entirely appropriate if we plan to clear the surgical backlog in 15 years, and it would be completely inappropriate if we want to clear it in two. So I'm flying blind here in being able to commend you or criticize the current plan. I think the people of Ontario deserve to know when they can expect what the OMA estimates is a backlog of 22 million services to be cleared. Could anyone clarify that for me?

Hon. Sylvia Jones: If I may, and then I will turn it over to Deputy Zahn: When the OMA came out with that number, very quickly we also found out and talked about how there were certain surgeries that did not happen as a result and were deemed not necessary anymore, for any number of reasons. I guess my concern in putting targets on particular surgeries in particular hospitals is that it could in fact be a disincentive if the hospital believes for any number of reasons that they would not be able to achieve it, and then they don't move forward on any of it.

Mr. Adil Shamji: But how do you pick a number, then, for what you want to invest if it's not tied to any sort of end goal?

Hon. Sylvia Jones: Well, it is tied to an end goal, and that is to deal first with what we call the long-waiters, the people who, because of the pandemic, have had to have their scheduled surgeries delayed and ultimately shift to that long waiting list, but—Deputy Zahn?

Mr. Adil Shamji: Yes. I'd love to hear the rest of the goals.

Dr. Catherine Zahn: The long-term goal is that long-waiters—not the long-term goal; the medium-term, which is March 31—

Mr. Adil Shamji: In 2023?

Dr. Catherine Zahn: In 2023. That will probably be extended because of the current situation with health human resources and the pediatric issues extant, but it would be close to that. Then, following that, we will continue with the mobilization of surgery as health human resources become available to continue to clear that backlog.

As I'm sure you know, there is a surgical wait-list that has been in existence for some time, and if we were able to clear the long-waiters, we would be very close to the usual number of wait times.

The Chair (Ms. Goldie Ghamari): Five minutes.

Dr. Catherine Zahn: I'm just going to turn it over to Peter, if he wants to add anything.

Mr. Peter Kaftarian: A couple of data points for you: I don't know if this was mentioned. Throughout the pandemic, access to all emergent and urgent surgeries was preserved; 99.3% of the most urgent procedures were achieved. For the long-waiters who the deputy has talked about, the goal of the investment this year was to get the excess of long-waiters back to where it was pre-pandemic, and then we are working right now through our annual multi-year planning process on how we target those long-waiters going forward and reduce it even further. Those, I think, are the key—

Mr. Adil Shamji: Sure. What about things like the 400,000 mammograms that haven't been performed yet, for which there is a backlog? The OMA reported that maybe about three to four weeks ago.

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Hon. Sylvia Jones: As I mentioned, in diagnostic testing, we're actually very close to our pre-pandemic numbers.

Deputy Zahn, did you want to go into more detail?

Dr. Catherine Zahn: I don't have any more detail than that, in particular, unless ADM Kaftarian does.

Mr. Peter Kaftarian: We have had some discussions about different numbers in the public domain. I think there are different ways of tracking backlogs. One of them could

be looking at billings and what billings were like pre-pandemic versus during pandemic and post, so, for example, a trip to a primary care doctor for blood work that you'd get could count as a procedure, depending on who is tracking it, whereas when we're talking about long-waiter procedures, we're talking about a surgical procedure as opposed to, for example, routine blood work. So I think we're not necessarily using the same denominator when the ministry is tracking a long-waiter compared to what some other organizations may deem to be a behind procedure, if that makes sense.

Mr. Adil Shamji: Can you help me understand how the potential proliferation of independent health facilities will fit into this plan of clearing backlogs?

Hon. Sylvia Jones: Well, I think, respectfully, it's all about adding capacity to a system. We have, and we in Ontario utilize, independent health facilities to ensure, frankly, that we don't have the long-waiters, the waiting, that I don't think anybody finds acceptable. So as we see—and we always talk about cataracts, because they are a large percentage of our independent health facilities—we've seen it as a very successful model to ensure that people have access to it closer to home, so you will see that instead of having to travel into the GTA. We just had some comments about northern Ontario, so—

Mr. Adil Shamji: Agreed. But just to redirect you slightly, respectfully, Minister: Dr. Zahn had pointed out that the primary goal is to have the very-long-waiters completed by March 2023, by which time, I suspect, it would be impossible to have any additional new independent health facilities up and running. So once that primary goal has been met, what is the purpose of any further—I'm not necessarily disputing the need for IHFs, but how will that fit into the plan after March 2023?

Hon. Sylvia Jones: We have a growing population in Ontario. We have a population that rightfully expects and deserves to have some of these surgeries and some of these performed in a more localized area and—

The Chair (Ms. Goldie Ghamari): One minute left.

Hon. Sylvia Jones: I'll turn the rest over to Dr. Zahn.

Dr. Catherine Zahn: The issue with the independent health facilities—if we speak specifically about cataracts right now, there is the physical capacity in the current independent health facilities to expand quite a bit. So as we're thinking ahead and defining what the ultimate number of these entities is, we can actually get started. It's a matter of distributing the funding to existing facilities. Most of them that do cataracts are associated with a hospital and have the appropriate supports in place to actually expand—

Mr. Adil Shamji: Very quickly, because I have seconds left: Are you able to comment on the proportion between not-for-profit and for-profit IHFs that are being funded right now?

Dr. Catherine Zahn: I actually don't know the answer to that.

Mr. Adil Shamji: Can someone get that for me?

Dr. Catherine Zahn: For-profits, I can tell you, is very small, but we can get that number.

Mr. Adil Shamji: And I'd love to know how that fits into the plan moving forward, as well, please.

The Chair (Ms. Goldie Ghamari): Thank you very much. That's all the time that we have.

We'll now turn to the government. MPP Oosterhoff, you may begin.

Mr. Sam Oosterhoff: My thanks to the minister and her team for joining us here on a beautiful afternoon. I appreciate all of your time and your passion for health care here in the province of Ontario.

I know that a key part of our budget and, frankly, a key challenge in what we've been hearing from the health care sector is health human resource staffing. We know, of course, that our government is making tens of billions of dollars of investments into crucial hard infrastructure. I'm thinking of some three new hospitals coming to the Niagara region: the West Lincoln Memorial Hospital, the south Niagara hospital and expansions at the Hotel Dieu Shaver rehabilitation site, and of course, new hospice beds being added, new investments in mental health facilities. But we need the people to make sure that all of those sites are well staffed. I'm very, very sure that you're acutely aware of that need, and I know that you've been working on ensuring that many actions are taken.

Minister, could you walk the committee through some of the actions that your ministry and your team are taking to ensure that each and every hospital bed and each and every new facility that's being added and expanded and renovated in this province has the staffing that is needed? I know that this isn't a challenge unique to Ontario; there are other provinces, other places in North America that are also dealing with this need. I'm wondering if you could walk us through some of the specific steps that your ministry is taking to address human resource challenges and invest more in building up our health care human resources.

Hon. Sylvia Jones: Thanks for the question.

I'm going to start where I started with my opening remarks. I'm full of gratitude and thankfulness for the health human resources staff who have been working under, frankly, what is unprecedented challenges under COVID-19.

Having said that, because of the quantum of investments and expansions that our province has committed to, both in long-term care and in health care—in community, in hospital—we knew that there was going to be a need for further and future expansions on the health human resources side, which is why we've done expansions like the first new medical school in decades—two, in fact—and which is why we have made investments and expansions in the Learn and Stay program for RNs. So all of those pieces, together, really speak to a commitment to expanding the workforce pie, if you would.

I will turn it over to Deputy Zahn for further details.

Dr. Catherine Zahn: Thank you, Minister.

Thank you, member, for the question. You mentioned earlier that we have short-, medium- and long-term initiatives in play. Over the ultra-short term, we are looking at

internationally educated nursing and other health professions staff, changing models of care, and accelerated programs like the extern programs and Learn and Stay type of programs. Over the medium term and long term, we have a very complex plan that is related to the increased educational facilities that were just mentioned, but also very specifically to activate—in the more medium term, as that is several years down the road—the opportunities that are available through the current universities and the hospitals for training opportunities.

With that, I will turn it over to director David Lamb to give some details about the numbers.

Mr. David Lamb: As the deputy said, HHR, health human resources, were paramount for the ministry and the government from the very beginning of the pandemic, as they always have been, and we can assure you that what's under way today and what has been done in the last couple of years shows that it continues to be so today.

As the deputy also noted, the challenge that we have faced relates to the ability to provide capacity in the very immediate term and short term while we continue to build capacity in relation to recruitment—but also working on retention in the medium term and the longer term.

The short-term programs that have been instituted over the course of the last two years have added something in the region of 12,300 staff in the short term—these are programs many of which run today and have added that number of staff. To break that down somewhat for you, that is some 9,100 externs, nursing preceptors and also nurses through our recruitment programs; some 2,600 personal support workers and supportive care workers; as well as some 400 staff who are also unregulated, who have been supporting the pandemic in various capacities.

Since the summer of 2020, the minister's fall preparedness plan—the first one, in 2020—invested some $52.5 million to recruit, retain and support over 3,700 health care workers and caregivers, to ensure continuity of safe care for patients and long-term-care residents.

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Amongst other things, this investment supported Ontario's long-standing Nursing Graduate Guarantee program, which was discussed earlier on today and which provides new graduate registered nurses and registered practical nurses with temporary, full-time employment, over and above the staffing complement within a hospital, to support successful transition to practice and full-time employment. It's very important that as we build recruitment, we're also able to provide services to onboard and allow them to be able to ensure that we have good retention.

The program provides 20 weeks of funding for each new nurse approved to participate in the program, and includes 12 weeks of funding for the nurse's transition to practice and then eight weeks of funding to reinvest in existing front-line nurses and their professional development.

In 2021-22, more than 1,500 new nurses were matched to employers through the NGG program. So far, as I mentioned earlier on, in 2022-23, some 1,400 new nurses have matched to employers through the NGG program, so an increase over previous years.

This plan also, though, as we mentioned today, supported the ministry's Community Commitment Program for Nurses, which offers registered nurses, registered practical nurses and nurse practitioners a $10,000 incentive in return for a one-year commitment to practise in a hospital, a long-term-care home, or a home and community care agency in high need. This first iteration of the program placed over 800 nurses with health care employers in need in the province. The ministry has since enhanced and extended this program, and I will talk more about that later in my remarks.

The fall preparedness plan of 2020 also invested in the personal support worker return-of-service program, which offered a $5,000 incentive to PSWs in return for a six-month commitment to work in a high-need Ontario long-term-care home or home and community care agency. We've now offered two iterations of this program, which has placed something in the region of 1,500 PSWs in long-term-care homes and home and community care service providers. More importantly, the program matched these PSWs with the health care providers that need them the most.

While COVID-19 has been a testing time for the system and for us all, the PSW return-of-service program and the Community Commitment Program for Nurses are examples, actually, of programs that were instrumental during the pandemic, and can be instrumental to us now as we work towards continued staffing and addressing the needs of the system that we have today.

We did also look at other programs and abilities to be able to generate staff and support very quickly. In November 2020, for example, we launched the Ontario Workforce Reserve for Senior Support program. This program recruited, trained and deployed non-health care professionals as resident support aides to long-term-care homes that needed HHR support. The program itself has fully trained 350 resident support aides, and, so far, 280 have been deployed to long-term-care homes. This program is also available to support hospitals and vaccinations.

You've heard mention as well earlier on today of the extern program. The extern program was effectively born of the result of the call that we heard from all of our health care providers in training, those that aspired to join our health care workforce and who wanted to help us as they learned. In January 2021, we started to see our first spike in the number of patients in critical care, and the government launched the program to add an immediate influx of nursing students to provide something in the region of 430,000 hours of extern care in up to 12 hospitals with critical COVID-19 related HHR gaps.

Over the course of the year, from April 16, 2021, the program was extended to paramedic respiratory therapists, medical undergraduate students and to an additional number of hospitals, bringing the total number of hospitals that are participating in the program to almost 60—so extern nurse providers in training, then we added those other providers in training to support the program. Since then, to

date, we have seen the hiring of over 4,700 externs, with another 1,200 of those then going on to be hired as the regulated health professionals we knew they would be, in the jobs and in the locations where they were hired as externs.

A number of these programs, including externs and our Medical Resident Redeployment Program, have been extended for 2022-23 fiscal year, and they continue to support not only critical care capacity but also surgical capacity across the province and system recovery in hospitals.

In addition to increasing the number of providers on the ground, we knew that it was important to support the existing workforce. Early in the COVID-19 pandemic, many employees were reporting issues with fatigue, low morale and difficulties in retaining staff, particularly amongst those that were lower paid.

Recognizing that front-line health care workers faced a high risk of exposure to COVID-19, temporary wage increases were implemented last summer to stabilize Ontario's health care workforce. The temporary pandemic pay program implemented by the government provided eligible front-line public sector workers in health care and other sectors with a top-up wage of $4 per hour and a $250 lump sum payment each month to those working more than a hundred hours a month, for a 16-week period from April 24, 2020, through August 13, 2020. As the deputy said earlier, over 230,000 of Ontario's front-line health care workers received pandemic pay, stabilizing the system in a period of crisis. Of the eligible workers, the most significant occupations represented were nurses—roughly 41% of the 230,000—and then personal support workers, at about 21%.

The PSW temporary wage enhancement in October 2020 then followed the government announcing a $461-million investment to provide temporary wage increases to personal support workers and direct support workers in home and community care, long-term care, public hospitals and social services.

In March 2021, the government invested an additional $239 million to extend the temporary wage enhancement for personal support workers and direct support workers in publicly funded home and community care, long-term care, public hospitals and social service sectors until June 30, 2021. The government is now investing $2.8 billion over the next three years to make this temporary wage enhancement program permanent.

It really is very important to acknowledge the key role that personal support workers play in providing care to patients, clients and residents across the system in long-term care, retirement and social service sectors, particularly, in the COVID pandemic. The role of personal support workers during the COVID pandemic has really highlighted the value and the work that's being done by them and also by other direct support staff to support the system. Acknowledging this, the government has acted quickly and decisively to build the PSW workforce during the pandemic and for the future.

In February 2021, the government announced the accelerated personal support worker program to train 8,200 personal support workers. This program is delivered at Ontario's 24 publicly assisted colleges and offers a six-month, tuition-free PSW training program, including clinical placement stipends for students.

In April 2021, the government announced a personal support worker bursary program, providing tuition grants and clinical placement stipends to as many as 4,000 personal support worker students at 23 district school boards, and 4,000 personal support workers at private career colleges in Ontario.

Therefore, the government has committed over $200 million to these programs and, thus far, has trained almost 15,000 much-needed personal support workers over the course of 2021-22 into 2022-23.

Further, in the 2021 fall economic statement, the government committed to training thousands more personal support workers in 2022-23. Up to 12,000 PSW students at public colleges, private career colleges and district school boards are anticipated to receive financial supports in 2022-23.

It's really important to note, when we're talking about these numbers, that in any given year up to 2019 the number of PSWs that were trained historically was something in the region of 6,500. So what's been committed to, effectively, in the original $200 million, was some 16,200 PSWs, and then, through the fall economic statement, adding another 12,000—which originally was 8,000, now becoming 12,000. So you can see that the number of the PSWs we're looking to add to the system in the course of the next year or so is pretty much unprecedented.

In relation to nursing enrolment expansion, the government is also taking bold steps to grow our province—

The Chair (Ms. Goldie Ghamari): Four and a half minutes left.

Mr. David Lamb: Thank you. In 2021-22, $35 million was invested to increase enrolment in nursing education programs in publicly assisted colleges and universities to introduce approximately 1,130 new practical nurses—RPNs—and about 870 registered nurses into the system.

As has been mentioned a couple of times earlier on in the day, the 2021 fall economic statement included investments of around $342 million that, in amongst other things, will add 1,000 registered nurses and 500 registered practical nurse positions to the nursing education assistants—2,000 to start with, one bolus of 2,000 nurses making their way through the system, and then with the 2021 fall economic statement a further 1,500 every year steady state, working their way through the system.

1450

And $100 million is also being invested to add over 4,000 nurses by 2024-25 to support training of thousands of personal support workers and registered practical nurses who want to advance their careers in long-term care and home and community care. So this is different from the standard program, this is a bridging program where you have PSWs who wish to become registered practical

nurses and where you have registered practical nurses who wish to become registered nurses.

It's really important to note the fact that a lot is being done to actually ensure that as we grow the nursing workforce, we're working as hard as we can to distribute that nursing workforce where it's needed most. You will have heard mentioned earlier on all the Community Commitment Program for Nurses and the program that we talked about earlier on has had some changes made to it. It now offers new nurses and those who have been away from practice for more than six months a $25,000 incentive in exchange for a commitment to practise for two years in a high area of need in the province. Through this program, we hope to place up to 3,000 nurses in areas of need through the next couple of years with some 1,500 or so in urban areas and 1,500 or so in northern areas. So far, over the course of this year, we have already placed something in the region of 600 nurses and more will be added between now and the end of the fiscal year.

You would have also heard mention from the minister of the new Learn and Stay grant—work that's done by the Ministry of Colleges and Universities and ourselves—starting in spring of 2023, up to 2,500 eligible post-secondary students who enrol in priority programs, such as nursing and paramedics to work in underserviced communities in the region where they studied after graduation and they will be eligible for that grant funding. So this takes people at the beginning of their program for distribution as opposed to the end of the program with the CCPN.

And then lastly, I would say that we've also heard mention of the physician workforce and what's being done to grow that. In 2022, the government announced a significant expansion of medical school education in Ontario, adding 160 undergraduate seats and 295 post-graduate positions over the course of the next five years. This is the largest expansion of undergraduate and post-graduate education in the last 10 years or so, and it intends to increase access to both family and also specialty physicians across the province. Training more doctors will ensure that Ontario's access to health care they need where they need it and wherever live.

The Chair (Ms. Goldie Ghamari): One minute left.

Mr. David Lamb: Also, as you've heard, there is and will continue to be a focus on internationally educated health providers. They're a large part of our workforce. We're taking action to expand opportunities for international providers. The Supervised Practice Experience Partnership program provides internationally educated nurses with the opportunity to achieve the evidence of recent practice and language proficiency requirements to obtain their nursing registration. As of November 4, over 1,700 internationally educated nurses are actively enrolled in the program and over 900 have achieved registration to practise through this program since it launched in January this year. We've also approved regulation changes that will allow IENs to register in temporary class and begin working sooner while they work towards full registration.

The work of health workforce planning is never done though, and we are already planning for how we will move the system forward, how we ensure that we have the right size and mix of workforce to be responsive to the needs of Ontarians and the system, and part of this will be—

The Chair (Ms. Goldie Ghamari): Thank you very much. That concludes all the time we have for this round.

We'll now turn to the official opposition for the last round. You'll have just over nine minutes.

M^me^ France Gélinas: Thank you. I will continue with my long list of random questions that I had. When we stopped, I was asking if I can have a breakdown of the amount for base funding per hospital—is it possible to get the base funding amount that the government pays to our 142 hospitals?

Hon. Sylvia Jones: What I started to say was, I believe with the small hospitals they had an increase in their base of 5% and then there were increases for medium and large as well. But I will turn it over to Peter.

Mr. Peter Kaftarian: Are you asking about a specific hospital or all?

M^me^ France Gélinas: All of them. Just their base funding to the hospital.

Mr. Peter Kaftarian: Yes, so we can take that request back.

Minister, in response to your comment, for the smalls, I believe last year there was a 2% growth that they all received and then any additional funding on top of that. But we can take your request back, MPP Gélinas.

M^me^ France Gélinas: Okay. And for the previous year, and this year, 2021-22, and 2022-23, if available.

Mr. Peter Kaftarian: Understood.

M^me^ France Gélinas: Same thing when it comes to COVID-specific funding. Your government has given hospitals quite a bit of funding for COVID-specific initiatives, and I was wondering if I could get the breakdown as to how much COVID-specific funding went to every hospital.

Hon. Sylvia Jones: Those invoices or statements were submitted and reviewed and assessed by the ministry, so it would not be consistent in terms of per bed. It depends on what they submitted to the ministry for COVID-related expenses.

M^me^ France Gélinas: No, I realize that. I'm not asking for a per diem or per bed or whatever. I'm just asking: Where did the money go? To which hospital did it go? That's all. When you have your response, organized by LHIN would be really cool.

Hon. Sylvia Jones: Chair, would that not be in the hospital annual reports?

M^me^ France Gélinas: I wish it was, eh? But they lump it up and some of them divided it by the screener—it's impossible to follow at my end. I'm hoping that, given that you gave the money, you know who you gave the money to.

Dr. Catherine Zahn: That is possible. I believe, when we finished the last time, that I was starting to say that the hospitals received funding from multiple streams. So to your point, there is an opportunity to have the core expense budget that an individual hospital has and track that over time, and we should be able to identify the dollars that were spent by hospital for COVID expenses.

Mme France Gélinas: Very much appreciated.

My next question has to do with the permanent and the temporary hospital beds in operation. I will pick a date: I'll pick April 1, 2022. It is really hard for me to find this. I'm hoping that they report to the ministry as to the number of permanent and temporary hospital beds in operation on April 1, 2022. It would be very helpful to have this by clinical area, and, again, organized by LHIN would be handy, but alphabetical order would work too. Is this something feasible?

Dr. Catherine Zahn: I'm not sure that level of breakdown of where exactly it went in the hospitals would be possible, but we can see what is available and what level it goes down to.

Hon. Sylvia Jones: You're referencing surge beds?

Mme France Gélinas: In part, but some of them are temporary.

The Chair (Ms. Goldie Ghamari): Five minutes.

Mme France Gélinas: In my area, we've ha temporary beds in a hotel for over two years now—two and a half years, actually. So I'm wondering if—I'm sure we're not the only ones. I'm just wondering as to how many permanent and how many temporary hospital beds presently exist in Ontario. I picked the date of April 1, but if you have a closer date to this, I'm happy, but April 1, 2022 would be quite sufficient.

Dr. Catherine Zahn: I'm going to ask Associate Deputy Minister Kaftarian for—I want to say 3,000, but maybe you could say it more specifically and eloquently?

Mr. Peter Kaftarian: Sure. Hi. Peter Kaftarian, associate deputy minister, clinical care and delivery, Ministry of Health.

This past year and earlier in the last couple of years, there were temporary beds approved, including examples of beds that could be in a retirement home or hotel. Effective this fiscal year, many of those temporary beds continue to stay in use. The total is now approximately 3,500 temporary surge beds, on top of existing hospital capacity. We're currently working with OH and the hospitals about which of these temporary beds make sense to continue to be temporary—because they're time-limited, or some of them are in hospitals, so it doesn't make sense that some of these temporary beds should be converted into permanent beds, based on the demand. That work is ongoing right now, as we plan for next year. But the entire 3,500 surge beds that the minister and deputy referenced were all temporary, for one year only—the funding was approved for this fiscal year for temporary. And the overall baseline for hospital capacity is in the 30,000-bed range.

1500

Mme France Gélinas: So will I be able to get that per hospital?

Mr. Peter Kaftarian: Just for clarity—on the surge beds? Yes, we can take that back.

Hon. Sylvia Jones: Chair, that would also be public information.

Mme France Gélinas: If you can direct me as to where I can find that public information, let me know—I'm pretty good at searching, and the questions that I ask are because I can't find it.

Hon. Sylvia Jones: We'll do that.

Mme France Gélinas: But I'm open—if you tell me where to search, I'm more than willing.

Coming back to the beds in operation, if you're able to answer my question—are you able to answer per Ontario health region or old LHINs, or is this not how it's being collected?

Mr. Peter Kaftarian: I believe the way it's tracked now is by OH region; not on a by-LHIN level.

Mme France Gélinas: Okay. It was very interesting, listening to the director of capacity and health force planning telling us about everything that the government had done to bring more people into jobs like PSWs, into jobs like nurses and all of this. Did you have a look at all as to the impact of Bill 124 on the number of them who are leaving the profession? Every day, I have nurses, sort of my age, who I've worked with before coming to me to say they can't take it anymore, and the reason why they leave is because they feel disrespected with Bill 124.

The Chair (Ms. Goldie Ghamari): One minute.

Mme France Gélinas: They would like to stay longer, they would like to collect a full pension and all of this, but they don't because, with Bill 124, they feel really disrespected. Do you have any thoughts as to how many health care workers we lost because of Bill 124?

Hon. Sylvia Jones: Similar to the wage-enhancement question earlier in committee, it's very difficult to track the "what if"—did it retain, did it encourage people to stay, or did it, in fact, cause an exodus? Anecdotally, we ask regularly, through Ontario Health, whether they are seeing exoduses—when, for example, the second tranche of the $5,000 retention pay went in. We're not seeing those numbers tracking upwards after the second tranche of the $5,000 retention pay was given. You're playing a scenario guessing game of, "If you had done it, what would have happened"—

The Chair (Ms. Goldie Ghamari): Thank you very much. This concludes the committee's consideration of the estimates of the Ministry of Health.

Standing order 69 requires that the Chair put, without further amendment or debate, every question necessary to dispose of the estimates. Are the members ready to vote?

Shall vote 1401—

Mme France Gélinas: Recorded vote.

The Chair (Ms. Goldie Ghamari): For all of them, or just this one?

Mme France Gélinas: All of them.

The Chair (Ms. Goldie Ghamari): MPP Gélinas has requested a recorded vote for all of the votes.

Shall vote 1401, ministry administration program, carry?

Ayes

Jordan, Martin, Oosterhoff, Pang, Rae, Wai.

Nays

Gates, Gélinas, Shamji.

The Chair (Ms. Goldie Ghamari): I declare the motion carried.

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

Ayes

Jordan, Martin, Oosterhoff, Pang, Rae, Wai.

Nays

Gates, Gélinas, Shamji.

The Chair (Ms. Goldie Ghamari): I declare the motion carried.

Shall vote 1403, digital health and information management program, carry?

Ayes

Jordan, Martin, Oosterhoff, Pang, Rae, Wai.

Nays

Gates, Gélinas, Shamji.

The Chair (Ms. Goldie Ghamari): I declare the motion carried.

Shall vote 1405, Ontario health insurance program, carry?

Ayes

Jordan, Martin, Oosterhoff, Pang, Rae, Wai.

Nays

Gates, Gélinas, Shamji.

The Chair (Ms. Goldie Ghamari): I declare the motion carried.

Shall vote 1406, population and public health program, carry?

Ayes

Jordan, Martin, Oosterhoff, Pang, Rae, Wai.

Nays

Gates, Gélinas, Shamji.

The Chair (Ms. Goldie Ghamari): I declare the motion carried.

Shall vote 1412, provincial programs and stewardship, carry?

Ayes

Jordan, Martin, Oosterhoff, Pang, Quinn, Rae, Wai.

Nays

Gates, Gélinas, Shamji.

The Chair (Ms. Goldie Ghamari): I declare the motion carried.

Shall vote 1413, information systems, carry?

Ayes

Jordan, Martin, Oosterhoff, Pang, Quinn, Rae, Wai.

Nays

Gates, Gélinas, Shamji.

The Chair (Ms. Goldie Ghamari): I declare the motion carried.

Shall vote 1416, health services and programs, carry?

Ayes

Jordan, Martin, Oosterhoff, Pang, Quinn, Rae, Wai.

Nays

Gates, Gélinas, Shamji.

The Chair (Ms. Goldie Ghamari): I declare the motion carried.

Shall vote 1407, health capital program, carry?

Ayes

Jordan, Martin, Oosterhoff, Pang, Quinn, Rae, Wai.

Nays

Gates, Gélinas, Shamji.

The Chair (Ms. Goldie Ghamari): I declare the motion carried.

Shall the 2022-23 estimates of the Ministry of Health carry?

Ayes

Jordan, Martin, Oosterhoff, Pang, Quinn, Rae, Wai.

Nays

Gates, Gélinas, Shamji.

The Chair (Ms. Goldie Ghamari): I declare the motion carried.

Shall the Chair report the 2022-23 estimates of the Ministry of Health to the House?

Ayes

Jordan, Martin, Oosterhoff, Pang, Quinn, Rae, Wai.

Nays

Gates, Gélinas, Shamji.

The Chair (Ms. Goldie Ghamari): I declare the motion carried.

That concludes the estimates for the Ministry of Health.

Are there any questions or comments before we continue? No.

Members, pursuant to standing order 63(e)—

Interjection.

The Chair (Ms. Goldie Ghamari): Yes?

M^me^ France Gélinas: When can we expect the questions that were not answered, where they promised us that they would give us an answer—when will we see the list of those questions and when will those lists be sent to them?

Interjection.

The Chair (Ms. Goldie Ghamari): The Clerk has informed me that they will answer when they can. There is no deadline.

M^me^ France Gélinas: Yes, I know that. My question was, when will I see the list of questions that have—

Ms. Amanda Boyce: I've been keeping track. I will be producing a list as soon as draft Hansard comes out. So it will be within a week we can assume, unless there's some of delay in draft Hansard.

M^me^ France Gélinas: Thank you.

The Chair (Ms. Goldie Ghamari): Thank you.

COMMITTEE BUSINESS

The Chair (Ms. Goldie Ghamari): Members, pursuant to standing order 63(e), no estimates shall be considered in the committee while any matter, including a procedural motion, relating to the same policy field is being considered in the House.

Bill 26, An Act to amend various Acts in respect of post-secondary education, is currently being considered in the House. As this bill relates to the Ministry of Colleges and Universities, I rule that today's meeting would contravene standing order 63(e). This meeting is therefore cancelled.

Are there any questions or comments? MPP Martin.

Mrs. Robin Martin: I'd like to move a motion.

The Chair (Ms. Goldie Ghamari): Okay.

Mrs. Robin Martin: I move that the committee meet tomorrow, Tuesday, November 15, at 6 p.m., in closed session, for the purpose of organizing committee business.

The Chair (Ms. Goldie Ghamari): MPP Martin has moved a motion. She's going to be putting it up on the screen. Is there any objection to this motion? Seeing none, are members are prepared to vote? Yes—

Interjection.

The Chair (Ms. Goldie Ghamari): I thought you'd read it. Yes, MPP Gélinas?

M^me^ France Gélinas: Could we do a friendly amendment and take out "in closed session"? Organizing committee business is nothing that anybody—so, I would suggest a friendly amendment that we meet tomorrow at 6 o'clock for the purpose of organizing committee business.

The Chair (Ms. Goldie Ghamari): Would you like to formally make this amendment?

M^me^ France Gélinas: Yes, please.

The Chair (Ms. Goldie Ghamari): Okay. We'll recess for five minutes.

The committee recessed from 1511 to 1516.

The Chair (Ms. Goldie Ghamari): Committee is now resumed. Before us, we have an amendment by MPP Gélinas. Is there any further debate?

MPP Gélinas, can you move the amendment?

M^me^ France Gélinas: I move that the motion be amended by striking out "in closed session".

The Chair (Ms. Goldie Ghamari): Is there any further debate? MPP Gates.

Mr. Wayne Gates: I'm going to ask the Clerk or the Chair to explain exactly, with what we're doing here, how it's going to affect the fact that we were scheduled to have a vote—less than two hours on long-term care. Will we still get to long-term care before this committee runs out of time?

Mrs. Robin Martin: Point of order.

The Chair (Ms. Goldie Ghamari): MPP Martin.

Mrs. Robin Martin: I think we're discussing the motion, and that's not—

The Chair (Ms. Goldie Ghamari): That's correct. I was going to mention it.

MPP Gates, we're currently debating the amended motion to—

Mr. Wayne Gates: I appreciate that, but before—

Interjection.

Mr. Wayne Gates: You can answer that after? Sure.

The Chair (Ms. Goldie Ghamari): Yes, there will be an opportunity to ask that question.

Any further debate on the amended motion? MPP Gélinas.

M^me^ France Gélinas: Really, we don't need to be in closed session to talk about the work that we will do. Everybody will see the work that we will do because we do it—it's on TV, it's on your Internet, it's on everywhere. We're there to represent the good people of Ontario. Let them hear what we have to say.

The Chair (Ms. Goldie Ghamari): Further debate? MPP Shamji.

Mr. Adil Shamji: I actually just have a question, because this is my first time participating in a parliamentary committee. What are we talking about tomorrow at 6 o'clock?

The Chair (Ms. Goldie Ghamari): Further debate? Seeing none, are members prepared to vote?

MPP Gélinas has moved an amendment to the motion. All those in favour, please raise—

M^me^ France Gélinas: Recorded vote.

The Chair (Ms. Goldie Ghamari): A recorded vote has been requested with respect to the amendment to the main motion.

Ayes

Gates, Gélinas, Shamji.

Nays

Jordan, Martin, Oosterhoff, Pang, Quinn, Rae, Wai.

The Chair (Ms. Goldie Ghamari): I declare the motion lost.

Turning now to the main motion: Is there any further debate? MPP Gates.

Mr. Wayne Gates: I'll go back to asking that question again—

The Chair (Ms. Goldie Ghamari): That would be after this motion.

Mr. Wayne Gates: Okay. I just want to make sure I get it out.

The Chair (Ms. Goldie Ghamari): I will make sure that you have an opportunity to ask the question.

Any further debate? MPP Shamji.

Mr. Adil Shamji: Just to MPP Gates's point, my only concern is—

The Chair (Ms. Goldie Ghamari): Again, that can be discussed after. Right now, it's just debate with respect to the motion that MPP Martin has brought forward.

Mr. Adil Shamji: I just don't know how to vote for this—depending on whether we're going to have time for long-term care or not. If we're going to have time for long-term care, I'm willing to support this motion; if we won't have time, then I won't. That's why I'm asking.

The Chair (Ms. Goldie Ghamari): This motion is at a different time—it's not related to the schedule that we have.

Are members now prepared to vote?

MPP Martin has moved a motion. All those in favour, please raise their hands. All those opposed, please raise their hands. I declare the motion carried.

Are there any further questions or comments?

Mr. Wayne Gates: Is this the time that I can ask—

The Chair (Ms. Goldie Ghamari): Yes.

Mr. Wayne Gates: I'd like to go through exactly what's going to happen with the schedule. I'm very concerned that we will run out of time and will not have the opportunity to talk about long-term care and, quite frankly, to ask questions to the minister.

I know my good friend MPP Oosterhoff has the same concerns that I have in his riding, where a lot of seniors—our aunts, our uncles, our parents, our grandparents—have died in long-term care.

Over 5,000 people have died in long-term care. And I said this about two weeks ago in this very committee room: Between 11 and 20 of our parents, our grandparents, our aunts, our uncles, our brothers and sisters are going to die today in long-term care.

We have a crisis in long-term care, and I think it's fair and I think it's reasonable of this committee on estimates to be able to talk to the minister and say, "How are we going to fix it?"

Are we just going to continue to let seniors die in the province of Ontario? What are we doing? It makes no sense to me.

And now, with what we're doing here, you're not even going to get to long-term care. Let's be honest: It was bad enough that we got less than two hours to talk about it, and now it's going to end up that we're not going to be able to talk about it.

I respect MPP Oosterhoff, but he knows as well as I do, because he has had the same problem in his riding that I've had in mine, where people we love are dying—and we're not going to have an opportunity to talk to the minister and say, "How do we fix this? How can we make it better, so that our parents or our grandparents who are going to these long-term-care facilities are taken care of, so that we can make sure they have staffing, so that we can make sure they're getting their medication properly?" We knew what happened when the military put the report out.

I'm looking at all you guys. Look at me. You guys have parents. You have grandparents. They're dying. You won't even give us an opportunity to talk to the minister. And I'm not saying I want to beat the minister up. I want to say, "Get some solutions. How do we fix it? How do we stop the dying in long-term care and retirement homes?" We can't do it if we don't get a chance to talk to him and ask him the questions: "Where are you spending the money? Are you spending the money in the right place? Do you think that if we got rid of Bill 124 and paid PSWs a fair wage and fair benefits we could fix long-term care?"

I don't understand why you're doing whatever you're going to do here to make sure we don't get to long-term care. That's what's going on. I'm not surprised by it, but you should be embarrassed by it, quite frankly—each and every one of you.

The Chair (Ms. Goldie Ghamari): MPP Gates—

Mr. Wayne Gates: I'll be quiet. I apologize.

The Chair (Ms. Goldie Ghamari): I would remind the members that their language should be parliamentary.

Mr. Wayne Gates: I apologize. I get passionate when seniors are dying.

The Chair (Ms. Goldie Ghamari): As a reminder, the reason that the schedule is the way it is is because it goes based off of selections made by the committee; it's in the order of selection. If that was a priority for you, you had every opportunity to choose that as the first subject, as the first ministry. The official opposition did have first choice, and you did not make it the first choice. So it's not appropriate to impute motive.

Let's make sure we keep our comments parliamentary. Thank you.

Mr. Wayne Gates: I understand that. My point is very clear. Even after we decided—where we normally get 15 hours for health, what did we get today? Three hours. They have a majority government. They can do whatever they want. I get it. I've been involved in politics a long time. We all know we do 15 hours for health. Health is in a crisis. People are dying in our hospitals. They're dying in long-term care. So it was up to them to say, "Yes, let's give them six hours, eight hours, 10 hours." And they decided to make sure, everybody on that committee—Mr. Oosterhoff, I don't think you were here when it was done. They decided to give it less than two hours.

I'm begging you: Let us talk to the minister to see if we can find solutions before more of our parents and our grandparents and our aunts and our uncles die.

The Chair (Ms. Goldie Ghamari): MPP Martin.

Mrs. Robin Martin: Chair, I move that the committee do now adjourn.

The Chair (Ms. Goldie Ghamari): MPP Martin has moved that the committee be adjourned. All those in favour, please raise their hands. All those opposed, please raise their hands. I declare the motion carried.

We will now adjourn and reconvene tomorrow morning, Tuesday, November 15, 2022, at 9 a.m. Thank you, everyone.

The committee adjourned at 1524.

STANDING COMMITTEE ON SOCIAL POLICY

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