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Tuesday 7 June 2016

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Mardi 7 juin 2016

Standing Committee on Estimates

Ministry of Health
and Long-Term Care

Comité permanent des budgets des dépenses

Ministère de la Santé
et des Soins de longue durée

Chair: Cheri DiNovo
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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON ESTIMATES

COMITÉ PERMANENT DES BUDGETS DES DÉPENSES

Tuesday 7 June 2016

Mardi 7 juin 2016

The committee met at 0902 in room 151.

The Clerk of the Committee (Mr. Eric Rennie): Good morning, everyone. As the Clerk of the Committee, it is my duty to inform you that neither the Chair nor the Vice-Chair are here this morning, so we'll be needing to elect an Acting Chair for the day. I remind members that, pursuant to standing order 117(b), the Chair of the Standing Committee on Estimates shall be a member of a recognized party in opposition to the government.

Are there any nominations for Acting Chair? Mr. Harris.

Mr. Michael Harris: I'd like to nominate Michael Mantha.

The Clerk of the Committee (Mr. Eric Rennie): Does Mr. Mantha accept the nomination?

Mr. Michael Mantha: I accept.

The Clerk of the Committee (Mr. Eric Rennie): Are there any further nominations? Seeing none, Mr. Mantha is elected Acting Chair. Mr. Mantha, could you please come to assume the chair?

MINISTRY OF HEALTH AND LONG-TERM CARE

The Acting Chair (Mr. Michael Mantha): Good morning, everyone. With no Vice-Chair or Chair, you have it a little bit better: You have me.

We are here today to resume consideration of vote 1401 of the estimates of the Ministry of Health and Long-Term Care. There is a total of six hours and 30 minutes remaining. Before we resume consideration of the estimates, if there are any inquiries from the previous meetings that the minister or ministry has responses to, perhaps the information can be distributed by the Clerk at the beginning in order to assist the members with any further questions.

Are there any items, Minister? Having heard none, when the committee adjourned on June 1, the official opposition had one minute and 10 seconds left in their round of questions. Mr. Harris, the floor is yours.

Mr. Michael Harris: All right, great. Minister, Deputy, good morning. Minister, I have over 600 postcards signed by the Scleroderma Society of Canada. I'll read it out to you.

"To the minister:

"On behalf of those living with scleroderma and pulmonary arterial hypertension in Ontario, I'm writing you to ask that you disregard the flawed CADTH and CDR recommendations that limit access to PAH treatments and ensure that:

"(1) Expert physicians are able to determine which medication is best for each PAH patient, both as initial and subsequent treatments during careful follow-up; and

"(2) All PAH patients have immediate, publicly funded access to all Health Canada-approved PAH medication.

"Now is the time to put those words into action as lives are at risk. Thank you."

I'll send them over. Minister, how would you like to respond to that?

Hon. Eric Hoskins: I'd like to thank you for the petitions, first of all. I know that our ministry has been working on the issue of pulmonary arterial hypertension for quite some time, including not just clinical experts but with advocates and those who represent individuals in this province afflicted with PAH. I am obviously familiar with some of the challenges that we're facing. In the absence of—

The Acting Chair (Mr. Michael Mantha): Thank you, Minister.

We will move on to France Gélinas of the third party.

M^me^ France Gélinas: I would like to focus on First Nations health, starting with—I'm not sure if it's the associate minister or you, Minister Hoskins. I questioned you, at the beginning of estimates, about the 96 long-term-care bed additions to Meno Ya Win health centre. They had made a very good case. But then, in the same week that I asked those questions, Minister Hoskins, you made an announcement of $220 million for First Nations health, and you announced 11 flex beds at Meno Ya Win health centre. Is this to take the place of the 96 long-term-care beds that they had been requesting?

Hon. Dipika Damerla: I'm happy to take that question.

Thank you, MPP Gélinas, for the question as well as your ongoing advocacy. I know you asked this question at the beginning of the session as well.

The answer is that the 11 flex beds are a short-term measure. We know that they have put forward, obviously, an application for 96 long-term-care beds. The conversation we've been having with the leadership—both at the municipal level with hospital officials as well as the First Nations—is, "Let's take a look at all of the needs that you have, the continuum of care that you need." Long-term care is one piece of the eldercare that

the Sioux Lookout area needs. We're working with them now. We're giving them these 11 flex beds. It's just the first step. But now let's look at: What is the best solution for the eldercare needs? We're not fixated on one answer. We're fixated on what's the best solution and working with them.

M^me^ France Gélinas: When you say you are working, who is actively working with them?

Hon. Dipika Damerla: The ministry would be working with the LHIN, with the Meno Ya Win hospital leadership—which has, as you well know, strong leadership from the First Nations represented on the hospital board—and the First Nations health authority. So we would be working with all of the stakeholders.

M^me^ France Gélinas: The North West LHIN has already endorsed the 96 long-term-care beds. They also have endorsed, in the $220 million—you are investing more into home and community care, and investing in other parts. But all of this has all been talked about, discussed, analyzed—and come to resolutions from the North West LHIN, from the Nishnawbe Aski Nation, from the four-party agreement, from the health centre itself, from the municipality of Sioux Lookout, from the municipal/First Nation friendship accord, from the Kenora district. Locally, they've had those discussions. They've already come to the conclusion that a whole lot of extra services need to happen, and within those are the 96 beds. So how much more "looking at this" before money starts to flow?

Hon. Dipika Damerla: Money, for a starter, is starting to flow. As you can see, we made the overall announcement—as well as the 11 flex beds. As you can imagine, you can't bring 96 beds online right away, so the 11 beds is something that we really wanted to make happen. We worked very closely with all of the stakeholders to make it happen in a very short period of time, and we're very pleased with that.

What we are going forward with is a planning grant. That is the next step. As you know, once we get a submission from any stakeholder, we look at it and then we say, "Here's a planning grant." What's really important here, MPP Gélinas, is that the planning grant—we're saying to them, "Look at the long-term-care facility, but come back to us and say what else you need. What would that continuum of care look like for the Sioux Lookout area?" We want to—

M^me^ France Gélinas: I want to hold you to your words here. You say "the long-term-care facility, plus what else," not "instead of."

Hon. Dipika Damerla: No. I think the right way to look at it is: "You have made a submission for a long-term-care facility. Here's a planning grant. Look at everything that you need. Once you look at everything that you need, maybe you're going to come back and say, 'We need 50 long-term-care beds, not 96, because we also want X, Y and Z.'"

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So all we're saying is, in principle, "We see you have a need. We have got a short-term solution. We have one proposal from you. Here is a planning grant for you to look at in greater detail and come to us with a robust solution that looks at the continuum of care, because that is the lens we are looking at for the entire province."

For the entire province, as you know, we have moved from—

M^me^ France Gélinas: Okay. I am interested, but my 20 minutes always end up being too short. I'm going to try to finish my sentence without having me be cut off this time.

I think, Minister, when you made the announcement, you talked about the hospital establishing long-term financial stability. Can I see any money attached to the statement that was made?

Hon. Eric Hoskins: Yes.

M^me^ France Gélinas: And how much would that be?

Dr. Bob Bell: I didn't hear that. Sorry, could you—

Hon. Eric Hoskins: The stability of the hospital, and is there funding attached to providing that stability—and there is. Are we sure about that? I think we'll have to—

M^me^ France Gélinas: There will be a whole bunch of questions for the $220 million.

Hon. Eric Hoskins: Okay. So on that one, if we could defer it, and I just would like the ministry just to—if you could repeat the question, so it's fully understood?

M^me^ France Gélinas: Okay. I'm trying to follow the money. Basically, some of it is the $220 million you announced and some of it, I'm guessing, comes from announcements that I should be able to find in the estimates, but I'm asking for your help because I cannot find it.

The first one is a commitment from the province to help this hospital—we're talking about Meno Ya Win—establish longer-term financial stability.

Hon. Eric Hoskins: For WAHA.

M^me^ France Gélinas: So we're looking for that. At the same time, you also made a statement that said you would increase physician services by 28%. I want to know: Is that for the Sioux Lookout zone?

Hon. Eric Hoskins: Yes.

M^me^ France Gélinas: And you went on to say 2,641 days.

Hon. Eric Hoskins: Correct, 2,641 days.

M^me^ France Gélinas: This is pretty precise, so I'm guessing there's pretty precise money attached to that.

Then you also talked about an interprofessional primary health care team in Sioux Lookout First Nations Health Authority.

Hon. Eric Hoskins: Correct.

M^me^ France Gélinas: I'm interested in knowing how much money is attached to that.

You went on to say "support culturally appropriate interprofessional primary care teams for First Nations"—seven in the north, three in the south.

Hon. Eric Hoskins: Correct.

M^me^ France Gélinas: My first question is: Are those AHAC or are they community health centres or are we talking about a new model, and how much money is attached to that?

Dr. Bob Bell: Maybe I could start off by saying—

M^me^ France Gélinas: Sure.

Dr. Bob Bell: —that you won't find it in the estimates, of course, because this was a post-estimates announcement with response to the public health emergency in the northwest being developed post-budget.

For example, if I may, Minister, just the first question you asked about primary care services in the northwest: At Sioux Lookout, 2,641 days is the number that comprises a 28% increase and the number of days of primary care.

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

Hon. Eric Hoskins: So that further breakdown—I'm not sure if you included cultural competency training. That was the fourth.

M^me^ France Gélinas: I was going to, but the deputy—

Hon. Eric Hoskins: So for the three that you identified and that fourth, the total funding over a three-year period is $37.4 million. I don't have with me the specific breakdown of each of those four within that total of $37.4 million, but that's something I'd be happy to discuss with the ministry, with my officials.

M^me^ France Gélinas: I just want to make sure the four are the physician services, the interprofessional primary care for Sioux Lookout—

Hon. Eric Hoskins: Yes, Sioux Lookout First Nations Health Authority.

M^me^ France Gélinas: —the seven AHACs, I'm guessing.

Hon. Eric Hoskins: So I can answer that question as well, but in a moment.

M^me^ France Gélinas: Then, the competency training. So those are the four?

Hon. Eric Hoskins: Yes, so for the four of those, this fiscal $9.4 million, next fiscal $24.4 million—oh, in fact, what I had when I said $37.4 million, that was the ongoing permanent beyond year three. Year three is $38.4 million, and beyond year three, on an ongoing basis, will be $37.4 million annually.

With regard to your question on the culturally appropriate interprofessional primary care teams—seven in the north, three in the south—we will be undertaking an engagement process with First Nations partners and front-line health care workers. It may include AHACs, but we will obviously be working with our partners to determine what the most appropriate construct, including localities, might be for each of these.

M^me^ France Gélinas: Is the door open to community health centres or to nurse practitioner-led clinics, or to completely new interdisciplinary models that have yet to see the light of day?

Hon. Eric Hoskins: We are open to new models. I would say we've begun the engagement process, in fact. Our priority would be that they are culturally appropriate and that they serve the needs through the delivery of interprofessional services. So we're open, through the discussions, to seeing what models might be most appropriate.

M^me^ France Gélinas: Okay. Usually, they like AHACs; I'm just going to put that out.

But there is no extra funding within that announcement for existing AHACs? Some of them do serve the areas that are under emergency right now.

Dr. Bob Bell: The AHACs will benefit from the interprofessional team increased compensation.

M^me^ France Gélinas: The $85 million.

Dr. Bob Bell: Yes.

M^me^ France Gélinas: Okay, but not through the $220 million. Although they do serve people from remote First Nations, they would not take part in that.

Dr. Bob Bell: The funding is for the 10 incremental primary care resources that may very well be largely AHAC.

Hon. Eric Hoskins: But there are certainly other elements of the programs within the $222 million, I think it is, which are province-wide—for example, the significant investment in diabetes—that they would potentially benefit from as well, of course.

M^me^ France Gélinas: Okay. When I asked you about primary care before—new community health centres, new nurse practitioner-led clinics, new AHACs—you are on record from the estimates saying, "No." Your answer was really short: that there would not be new AHACs, CHCs or nurse practitioner-led clinics. But through this announcement, we could see new AHACs, we could see new community health centres or we could see new nurse practitioner-led clinics?

Hon. Eric Hoskins: Yes.

M^me^ France Gélinas: Okay.

Hon. Eric Hoskins: Then that answer was from last year, presumably?

M^me^ France Gélinas: No, that was from the same week that you made the announcement. You were in estimates; that was before you went away.

But anyway, it doesn't matter. I like the new answer better than the old one.

Hon. Eric Hoskins: Oh. I'm going to suggest that I might have been responding in a general sense or perhaps to something else that was taking place, and not in reference to that aspect of your question.

M^me^ France Gélinas: I won't argue with you, but I will send you the Hansard and you—

Hon. Eric Hoskins: No, but I think, as a matter of clarification—and one of my staff members has suggested that's her recollection: that it wasn't specific to that element of a question that you might have asked.

I would be surprised, actually, just on recollection, that I would have responded to such a question in such a fashion, given the announcement that—

M^me^ France Gélinas: That was coming the same week?

Hon. Eric Hoskins: —was imminent.

M^me^ France Gélinas: I will give it to whichever staff it is to look on Hansard, and you can see my question and you can see the answer. But I like the new answer way

better, so I'm going to hold you to the new answer, which means that CHCs, AHACs or nurse practitioner-led clinics could see expansion in that model of care if the First Nations so decide within the 10 that have been announced, seven in the north and three in south.

Hon. Eric Hoskins: In partnership with themselves, yes.

Then last, if you'll allow me, it's possible as well that my response was in advance of any cabinet decision with regard to the funding that we more recently announced, and so if I was in fact responding to your question, that might have been the reason why I expressed that no decision had been made.

M^me^ France Gélinas: Okay; all good.

I'm moving into the announcement again, the $220 million for First Nations, specifically for public health and health promotion. You talked about expanding the northern fruits and vegetables program up to the four remaining northern regions—I get that—and on-reserve schools in Sudbury. There are no on-reserve schools in Sudbury. Atikameksheng Anishnawbek goes to R.H. Murray, and Wahnapitae goes to C.R. Judd, which are very good schools, but they're not on-reserve. So who did you mean?

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Hon. Eric Hoskins: I have slightly more detail here, and I'm sure you will tell me if this explains the confusion. It would include First Nations on-reserve schools in the Sudbury region.

M^me^ France Gélinas: Sudbury region, okay.

Le Président suppléant (M. Michael Mantha): Madame Gélinas, il vous demeure cinq minutes.

M^me^ France Gélinas: Il me reste cinq minutes.

Hon. Eric Hoskins: You're correct in the sense that it would provide—as expanded, as you've just alluded to—fruits and vegetables to an additional estimated 12,900 indigenous children, including 6,500 students on-reserve.

M^me^ France Gélinas: Okay. There are no on-reserve schools in Sudbury.

Hon. Eric Hoskins: Region—

M^me^ France Gélinas: And even when I look at the region, the next First Nation would be Mattagami, but they're not usually considered Sudbury region. Is Mattagami who you mean?

Hon. Eric Hoskins: I am sure that we're going to find out.

M^me^ France Gélinas: Okay. If you could let me know. This is a good-news announcement. If it's Sudbury region, there's a good chance that they're in my riding. Although it's called Sudbury, the member from Sudbury will explain to you that Nickel Belt covers a big part of Sudbury.

Hon. Eric Hoskins: Yes.

M^me^ France Gélinas: All right. You talked about creating a new associate medical officer of health role for indigenous health in the Sioux Lookout First Nations Health Authority. That would be for the health unit in—which health unit would that be?

Interjections.

M^me^ France Gélinas: And while you're there, if you could also answer about increased nursing capacity and public health services capacity.

Ms. Roselle Martino: Certainly. I'm Roselle Martino—

The Acting Chair (Mr. Michael Mantha): Can you introduce—

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

The Acting Chair (Mr. Michael Mantha): Thank you.

Ms. Roselle Martino: In terms of the medical officer of health position, it is in the Thunder Bay health unit. But just to be clear, the Thunder Bay health unit will just be the flow-through. The medical officer of health will be supporting the Sioux Lookout region. So it would be to support that.

M^me^ France Gélinas: Will he or she be in Sioux Lookout, or will he or she be in Thunder Bay?

Ms. Roselle Martino: No, he or she will be in Sioux Lookout. They may be going back to Thunder Bay to support some of the board requirements, but they will be servicing Sioux Lookout.

M^me^ France Gélinas: And be located in Sioux Lookout.

Ms. Roselle Martino: That is the intention, yes.

M^me^ France Gélinas: Okay. And, increased nursing capacity and public health services capacity: Is this specific, again, to Sioux Lookout, or is this for all of the Thunder Bay health unit area?

Ms. Roselle Martino: No, this is specific to Sioux Lookout. SLFN Health Authority had identified this as a gap in services, and that is what the minister's announcement supported.

M^me^ France Gélinas: How much money are we talking about?

Hon. Eric Hoskins: We have a partial breakdown. If you would like the figures, it includes what you just referenced, but also the—do we have more detail?

Dr. Bob Bell: We do.

Hon. Eric Hoskins: We do, okay. The establishment of the associate medical officer of health: $400,000, essentially annualized, beginning this fiscal year. Increasing the public health nursing capacity at SLFNHA and in communities: estimated at $2 million, essentially ongoing, beginning this fiscal. Increased public health service capacity to respond to needs identified through assessments in gap analyses: $2 million annualized, beginning this fiscal as well.

M^me^ France Gélinas: So that's on top. We have the increased nursing capacity. That's $2 million. Then we have the—

Hon. Eric Hoskins: Yes.

M^me^ France Gélinas: Oh, wow.

Hon. Eric Hoskins: The more general increasing of the public health service capacity at an additional $2 million.

M^me^ France Gélinas: Okay. It will flow through Thunder Bay, but it will be specifically for the Sioux Lookout First Nations Health Authority.

Hon. Eric Hoskins: Yes.

Interjection.

Hon. Eric Hoskins: The MOH position will be—

Ms. Roselle Martino: It will flow through Thunder Bay. The rest of it will go to Sioux Lookout.

M^me^ France Gélinas: To Sioux Lookout directly?

Ms. Roselle Martino: Right.

The Acting Chair (Mr. Michael Mantha): You have one minute.

M^me^ France Gélinas: One minute? Man, it goes by really fast, doesn't it?

I guess the last one—

Hon. Eric Hoskins: I do have the breakdown, if you want to know the physician services costs, the increase—in that minute.

M^me^ France Gélinas: Oh, do you? Okay, good.

Hon. Eric Hoskins: So $13.6 million is the existing funding that's allocated, so it's an increase of $3.4 million beginning this fiscal year and ongoing. That's for the increase in physician services in the Sioux Lookout zone.

For the interprofessional primary care model, specifically for Sioux Lookout First Nations Health Authority, we have $3 million annualized beginning this year. For elsewhere outside of Sioux Lookout, we have $2 million this year, $16 million next fiscal and the following year, and annualized estimated at $30 million. So it's an additional $30 million once it's fully rolled out for interprofessional primary care; for example, AHACs, family health teams, ACHCs or other models across Ontario.

The Acting Chair (Mr. Michael Mantha): Thank you, Minister. Merci, madame Gélinas. On va maintenant transférer au gouvernement. M. Thibeault.

Mr. Glenn Thibeault: Welcome, Ministers and Deputy Minister. It's great to see you here once again on this lovely Tuesday morning.

There are a few things I'd like to start off with. I'm going to talk a little about doctor supply, physician supply. I think that's something that's key for us to highlight, not only from the estimates point of view, but the work that your ministry has been doing in addressing this issue throughout Ontario. Specifically for me, maybe how I'd like to emphasize this is that I'm going to talk a little bit about some of the specifics that relate to Sudbury and northern Ontario in general, because that's something that I know we have been talking about a lot as a government and as MPPs.

I know my colleague from Nickel Belt mentioned earlier the Sudbury region, so I think I have to give credit to her, because this is her patent: She said that "Sudbury is the Timbit and Nickel Belt is the doughnut" is the best way to explain the two regions. For Canadians, we have a very clear understanding of a Timbit and a doughnut, although none of us here—we're talking about health, so all of those doughnuts and Timbits are calorie-free, of course—not that those new strawberry shortcake ones or anything are very tasty, not that I've had one, because I'm diabetic now and everything. Anyway, way too much revealing there, and way off track.

Hon. Eric Hoskins: Carry on.

Mr. Glenn Thibeault: Anyway, jumping back to doctor supply: I think it is important to emphasize that and bring it forward, especially for those of us in the north. I come from a community where, if you go back a decade, it was very concerning in the sense of the numbers of individuals who didn't have a family doctor.

I know we've done a lot as a government to address that. I think one of the things that has been paramount and very key in addressing that shortage is the opening of the Northern Ontario School of Medicine, both in Sudbury and Thunder Bay. I know that Dr. Roger Strasser, the dean there, has been extended till 2019. He's doing a phenomenal job. Dr. Saidi, who did my knee, is there teaching, and we're starting to see more and more of those high school students from the north, from all of our regions, going to these two facilities and then staying in the north.

That, I think, is something that's critical, because I can look to the opening of the Minnow Lake medical centre in Sudbury with Dr. Trebb and Dr. Pastre and—oh, jeez. I'm drawing a blank on the two other doctors who are there, but these are four individuals who graduated from the medical school and then stayed in Sudbury, which is so key for us, and it's so important for us to recognize that. I know our investments through your ministry in medical education have been key to that—again, not just with northern Ontario and the Northern Ontario School of Medicine, but overall in terms of the province.

If we look at the annual number of medical school graduates in Ontario, that has increased by over 60% since 2003-04 from approximately 592 to almost 1,000 grads by 2015-16. Not only are we now recruiting more doctors from other places and bringing more doctors to Ontario; we're also doing that grassroots push where we're getting individuals from high school going into medical school, or going to university and then going into medical school.

I think in 2015 there are also approximately just over 1,000 first-year residency positions dedicated to Canadian medical grads in Ontario. Of those, 200 positions are dedicated to international medical graduates, which I think is something that's important as well.

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In Sudbury, we're starting to see more and more individuals move to the north. We had Syrian refugees come, as many communities have, and we're embracing our immigrant community. Many family members are now coming to talk to me about how they can get their uncle, cousin, aunt, sister, brother and whomever into these international medical graduate spots. It's great to see that we have those as well.

I believe that the ministry spent approximately $150 million to support medical education in 2014-15, if those numbers I read were correct. Further, I think the ministry is also spending $360 million in 2014-15 on the salaries and benefits paid to over 4,700 medical residents in

Ontario's postgraduate medical training system, who deliver care to patients during their training. Not only is the northern Ontario medical school part of all of this investment; we're seeing, if I relate this back to my opening, which is the doctor supply for the province, that this is just so key and critical for us.

I know that my colleague Madame Gélinas worked hard with my friends from the City of Lakes centre. We were able to open a new clinic in Chelmsford, which was so key for addressing orphan patients in that region.

In the City of Lakes, Dave Courtemanche and the whole team have been doing such a great job of making sure that we can address what was a shortage of doctors in the north.

Really, I think if we're looking over the focused effort that we have done as a government—and the ministry has done, focusing on this—in the past 10 years, in the substantial investments in the education piece that I've talked about, we've seen a huge improved supply of doctors in northern Ontario and across the province. I know that the province is now going to adjust the number of doctors it trains, based on some analysis and detailed forecasting.

It's key to look at—since 2003 to 2014, the number of doctors in Ontario has increased by 30.8%. I think I've got that statistic correct. We went from 21,472 doctors to over 28,000, while the population only grew by close to 12%. We've seen a significant increase there. The ratio for doctors to every 10,000 people increased from 17% to about 20%—almost 21%. It's important to highlight, for those who are here, that these increases included almost a 28% increase in family doctors, from just over 10,000 to over 13,000; and we saw almost a 34% increase in the number of specialists, from just over 11,000 to almost 15,000 doctors. Those are some very important statistics for us to bring forward.

I can talk about—and I know my colleague from Nickel Belt can talk about—some of the great physicians that we have in Sudbury. I can think of Dr. Hourtovenko, a cardiologist, who's doing—I don't know what it's called—but it's some type of echo work, right? DM Bell, you probably know of that stuff, and Minister Hoskins, you probably know that stuff a lot better than I do. Dr. Hourtovenko and his partner, Karen, are just doing phenomenal work in terms of cardiology in Sudbury. That's something that's key for us because we were in Sudbury back in, oh, God, was it—

Hon. Dipika Damerla: The fall.

Mr. Glenn Thibeault: —the fall of last year, going down slides, making an announcement with our mayor about leading healthy lifestyles and changing the way our children—

Interjection.

Mr. Glenn Thibeault: Yes, the mayor went down the slide. Did you go down the slide as well?

Hon. Dipika Damerla: Yes.

Mr. Glenn Thibeault: I chose not to. I don't think my knee was well enough. That's part of the problem, right? Now that I've got a good knee, I can now join you on the slide the very next time.

I think the important thing is that we're really starting to instill in our youth and in our children to start leading healthier lives.

Swinging that pendulum will also help with health care because it's key that we have these doctors that I know I keep talking about in terms of our supply—that we have more and more doctors available for us. But it's also a proactive, positive thing for communities to do. I know that was a great investment that we made right across the province—it's great for us in Sudbury—to start engaging our youth in healthier activities so that the health care system becomes that backstop, not the first place that we need to go to. That's key and critical for us, to be able to just say, "You know what? We're doing proactive sides to health care, and not just waiting until we're sick to actually go see the doctors."

Those are some of the things that I think are key and important. As a father of two young daughters, trying to get them out there to be active—how many of us rode our bikes as kids and we had to be home before the streetlights came on? It was great in the summertime, but, boy, in the wintertime it was a lot of quick running, getting in great shape to run in the wintertime in winter boots and stuff.

Anyway, I know I'm rambling a bit, but—

Interjection.

Mr. Glenn Thibeault: Okay, you're—

Mr. John Fraser: I wasn't going to say anything, but—

Mr. Jeff Yurek: Are your caucus meetings that bad?

Mr. Glenn Thibeault: Yes.

It's my opportunity, now that I can talk about health care—again, just getting to the piece of doctor supply: We've opened many clinics within the Sudbury area, within the north, for family health teams. We've also seen Sudbury open up nurse practitioner facilities. I believe Sudbury was the very first community to open up a nurse practitioner clinic, which is great, because that helps us look at addressing some of those hard-to-serve communities where there's a population of 250 people or whatever the number is. This really does address a lot of the needs that we have in the north, so I think it's a good-news story for us, and I think we need to talk more about that.

We also have the HealthForceOntario Marketing and Recruitment Agency, which is something I think we should tout a little bit as well, because it helps communities with recruitment and retention and promotes opportunities in places that need doctors. I know that our chamber of commerce in Sudbury has been working with our city to do such great work in recruiting doctors throughout the north.

One of the things, when you wear your federal hat—once upon a time, I got to do that, as an MP. They closed our immigration office in Sudbury, and we were worried about how that would have some effects. But what that did is that we also had a few doctors who were looking to come to the north from other countries, and they said, "Why would I want to move to the north now if I have to

constantly go to places like Toronto or Montreal or the bigger cities to do my processing to be able to work here?" There are things like that that we—not "we"—have put up, roadblocks, that we've been able to find ways to work around.

I think it's key for us to recognize that we have done some great things. This ministry has done some great things in addressing recruiting doctors to the north—not just in the north, but all throughout the province.

I'll get to my question. I think it's key for us, as I keep saying, to talk about this, to highlight the important work that has been done. Maybe, Minister, can you talk to this committee a little bit about an update on the plan to ensure that we continue to have a stable doctor supply in Ontario? Maybe, as well, we can talk a little bit about the plan to enhance the distribution of doctors, not just across northern Ontario but right across our great province.

With that, I'll hand it over to you. Thanks, Minister.

Hon. Eric Hoskins: Thank you. It's a very important question, and I appreciate the time you took to elaborate, based on your own personal experience and that of the constituents whom you represent.

I'm also glad that you raised NOSM, the Northern Ontario School of Medicine. It's interesting in part because I graduated from McMaster University back in 1985. Mac was the first to have medical electives, and Sioux Lookout was primarily where the relationship had been built up.

Frequently, students from McMaster would gain that northern Ontario experience, the community would benefit, and, not infrequently—I have friends and colleagues who still reside there 30 years later, who would choose that because of their commitment to the community and the lifestyle, quite frankly. They decided to become full members of the community and reside there, and still do to this day.

I don't think any of us really understood just how impactful the Northern Ontario School of Medicine might be—adding that sixth medical school to the province. It has been pretty remarkable. I've had a number of meetings and many conversations with Dr. Strasser and was very pleased to see that he has been extended, because the work that he and his colleagues have been able to do to really maximize the impact of that opportunity—it's the output, but it's also the input, the intake to the medical school, that they work very hard on. A significant number of the students who enter the program come from the north.

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Really, there are a couple of things that have been determined to greatly influence where a physician practises: It's where they come from and where they do their training. This has combined both of those things, where the intake, including from First Nations communities—there is more work that needs to be done, but great effort is being made to ensure that First Nations residents of northern Ontario have that educational opportunity, and others who are resident in the north.

It has worked extremely well. You referenced the number of physicians in the north. I think the increase in the western part, the North West LHIN, was about 20%, in the number of physicians practising in the north since our government came into office in 2003. It's somewhat less, but nonetheless significant, through the North East LHIN as well.

We've invested a lot of money too, quite frankly, part of it through our northern and rural recruitment and retention initiatives, to recruit and to ensure that physicians who might be looking at the north as an opportunity choose the north, practise there and remain there. It's exceptionally important.

As you referenced, our first nurse practitioner-led clinic was in Sudbury. We now have 25 across the province. I met yesterday with the Nurse Practitioners' Association of Ontario. We spoke specifically of this issue. It's not even about how they are often an appropriate option in more remote communities; the satisfaction surveys for nurse practitioner-led clinics are exceptional. They just provide a tremendously effective, impactful, positive, high-quality service.

But also, the efforts that we've made for family health teams: There may be even more now, but my notes suggest that we have 42 family health teams that are located in the northern part of this province. That interdisciplinary approach to health care—again, the evidence demonstrates how impactful it is. Patients and families enjoy it and appreciate that holistic approach, that multidisciplinary approach.

We've dramatically increased the number of physicians practising in this province, to the point where it's estimated by survey that 94% of Ontarians have a primary care provider—that would be either a family doctor or, in certain circumstances, a nurse practitioner.

I think the most recent year in our statistics demonstrates that an additional 900 net new doctors began practising in Ontario over a one-year period, which represents about a 3% increase in the physician population in the province, and it's increasing at three or even almost four times the rate of population growth. That's important—and that's net. That is after we take into account retirements or the small number of physicians who might choose to move to another province. The net increase is a significant number, which allows us to go even further in terms of our ultimate goal and commitment: to ensure that every Ontarian who wants a primary care provider will be able to have one and be attached to one.

Le Président suppléant (M. Michael Mantha): Monsieur Thibeault, il vous demeure deux minutes en bref.

Hon. Eric Hoskins: Two minutes? Thank you.

I'd be remiss if I didn't, in the remaining—well, maybe I'll just carry on.

I know how absolutely anxious Denise Cole, who is the ADM for our human resources strategy, is to get up here and spend some time talking to you about this issue, but I'm not going to grant her that opportunity. Believe me, Denise has a lot on her plate in terms of her responsibilities as ADM, but she does an absolutely exceptional job. In fact, she was recently recognized, and

we should—I think this is important. Bob, do you want to come in? Because I'm going to misstate precisely what the acknowledgement is, but Bob, I think you could probably help me with this.

Dr. Bob Bell: Thanks, Minister, and thanks for tweeting about it. Denise was recently recognized in a book as one of the 100 accomplished black Canadians. I believe this was the initial nomination of ABCs, and the book will be coming out soon. There will be a gala dinner coming soon, where we'll get an opportunity to celebrate Denise. The list of the folks she shares space with in this book is extraordinary.

We are so proud of Denise—Minister, I know your team is, as well—that she has been recognized in this way. We are so fortunate that she brings her open and inclusive approach to the engagement of all citizens—international citizens, Canadian graduates—

The Acting Chair (Mr. Michael Mantha): Thank you very much, Minister. On va maintenant passer le discours à M. Harris et M. Yurek.

Mr. Jeff Yurek: I just want to start with a question for the minister. Good morning. I said good morning to Dr. Bell earlier, but I didn't say good morning to you too.

With the Ontario drug formulary, page I.19, number two on the page—I'll just read it to you, and then explain my question: "Any injectable drug product which received a notice of compliance from Health Canada on or after September 4, 2003, is ineligible for reimbursement as a DPP under the ODB program unless approved by the EO under the EAP."

Now, this has been a bone of contention for many a group of pharmacists who deal with delivering home care services throughout the province. We see this as a potential savings for the government down the road, and we just don't know why the government hasn't bothered to take a look at this. I mentioned it to Minister Matthews previously, and nothing got done with it.

Most generic medications and antibiotics have received a notice of compliance after that date, so technically a pharmacy has to use a brand name drug product, which is usually tremendously more expensive than a generic drug. So under this one little column in here, because you've put "2003," unless the pharmacy gets the EAP process done—you can't really do that for short-term antibiotic therapy—you either have to cheat the system in order to provide a cheaper medication, or bill the expensive one.

Pharmacists get upset at doing that, because at the end of the day, as the drug billing goes up, they're the ones who get cut down at the end of the line. I just want to know if you've reviewed it, your thoughts and why it's still sitting there.

Dr. Bob Bell: Thanks, Mr. Yurek. I think our executive officer for drugs, ADM Suzanne McGurn, probably has the best understanding.

Ms. Suzanne McGurn: Good morning. I apologize for my voice. I'm Suzanne McGurn. I'm the assistant deputy minister and executive officer for the Ontario public drug program.

Mr. Yurek, I will go back and double-check the specific legislation you refer to, but I do want to draw your attention to the fact that as of last Wednesday, on June 1, we did post some regulatory changes for a consultation, and it is in fact to address some of the types of concerns that you have identified: that there was a period of time for which products that predated legislative changes that were made in the early 2000s—that there were products that were unable to meet the criteria to be able to be listed on the formulary or moved from EAP, as an example, to the formulary. We are consulting on those right now.

Additionally, there were some older products for pain that are particularly important for palliative patients, which similarly could not meet pre-existing criteria. They are also posted for consideration to be able to make them appropriately accessible to individuals dealing with end-of-life care.

We'll double-check if that will address in whole the concerns you've identified, but I did want to draw your attention to that.

Mr. Jeff Yurek: Great. Thank you. I just wanted to point that out, because I just think the potential for savings there in the health care system is tremendous. There's a lot of generic antibiotic medication that has come out in the last five or six years that is being used in the hospital system, and we either have to order brand or the patient has to be switched if they want to be treated in home care. I think the idea is to get them out of hospital and get them treated.

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Ms. Suzanne McGurn: Maybe just as a last point, if I could also add: In your life, you will also be aware that the drug interchangeability for Health Canada for being able to determine a number of products as equal as generics for that purpose—there was a small portion that had not been previously captured. We did make changes last October. There is a very small portion—probably less than 5%. Again, in the regs that were just recently posted, there is a recommendation for some changes there to allow all generic products with designation of interchangeability to be able to be moved.

Mr. Jeff Yurek: Okay. I just also want to put the note—MultiVites in TPN is also needing an EAP in order to be covered, and that can sometimes keep someone in the hospital longer than need be—if the drug is actually available and they can get out of hospital. If you can take a look at that?

We might as well stay there, for now.

Ms. Suzanne McGurn: Okay. I'll do my best.

Mr. Jeff Yurek: You might have deflected this question, too.

Minister, you announced yesterday that coverage will be for the medication used for physician-assisted death. I'm wondering if there are changes upcoming—you mentioned palliative care. Right now, the process to get some of the medications covered: The doctor has to call the facilitated access system, which usually the pharmacist ends up calling and saying, "I'm acting on behalf of

the doctor," but you've got to wait 24 hours, and you're dealing with palliative care. Sometimes these medications—they need them the same night, and usually it's night when it's an emergency order.

So you're either causing the pharmacy, again, to bill the drug—hopefully, it gets approved—and eat the loss or the patient has to wait or go in the hospital for treatment. Is this being addressed? Can we tell people that we're actually going to expand the availability of palliative medications across the spectrum so that people can actually get the medication they need?

Ms. Suzanne McGurn: I would just remark that PA Fraser has similarly identified this problem to us and the concerns about the facilitated access program. The regulations that are posted for consultation right now, we believe, will address the vast majority of those pain-related medications that previously needed to be accomplished through the facilitated access program.

Obviously it would not change, for example, access to oxyNEO where there's some very specific criteria. However, we are doing a complete review to determine if that will appropriately adjust the access to support appropriate ease of access at end stage without having to go through a complicated procedure as people are being cared for at the end of life.

Mr. Jeff Yurek: And you're going to include more than just pain; right, like—

Ms. Suzanne McGurn: There is a number—

Mr. Jeff Yurek: There is also diazepam and—

Ms. Suzanne McGurn: Yes. There's a number of products. We are going through the list of what's captured right now to make sure it will address them all. Certainly during the consultation period, we will be hoping to get feedback from clinicians if it substantially addresses the concern.

Mr. Jeff Yurek: I would hope as well that you'll be dealing with pharmacists and how it affects their operations. They're usually the ones who get the call at 5 o'clock Friday night: "Get me the medication." How can we streamline the system and make it easier for them to get that medication?

Ms. Suzanne McGurn: Thank you for that. We do, when the regulations get posted, routinely send out those notices to all of the pharmacy associations etc., to ensure that they're aware of the posting and be able to get their feedback on these types of initiatives.

Mr. Jeff Yurek: I guess the other one is, the EAP process itself has a terribly long wait time. I had a constituent of mine who waited almost a year to get a no. It wasn't the doctor not putting in the proper reports. This patient has drastically deteriorated because he was waiting for this medication. Is there a way to speed up this process? Are you doing a review? Can we—

Dr. Bob Bell: While Suzanne is gathering her thoughts, I can tell you that when she became the executive officer for the Ontario publicly funded drug programs, after she had been on the job for about two months, she mentioned to me that one of the major things keeping her up at night was the lengthy wait times you're referring to, and that had been commented on by the Ombudsman as well.

I'm very proud of the work she has done, first of all, in getting rid of the backlog, increasing the number of staff and then subsequently putting in place a revision to the EAP which she'll describe.

Ms. Suzanne McGurn: Again, thank you for the questions. My background, as for many people who work in health care, is from a clinical background. The length of time that an individual—their clinical specialist or they themselves as a patient—has to wait to be able to determine whether they actually have access to a drug that their physician is prescribing to them is of critical importance.

A few things that I would like to point out: We have expended a great deal of energy during the past year to be able to get targets to the more appropriate targets just prior to Christmas. The type of things that we have done is that we have looked at how long we extend extensions for, being able to increase the number of staff. We've looked at moving some products from EAP to limited use. Some of the recommendations I spoke about in my last response actually came out of the same review: how many products were going through EAP because they simply could not meet the existing criteria to be moved to general benefits etc.

We have also been working with some of the high-volume areas to streamline the application processes, and going out on a significant amount of outreach. To your point, sometimes it is about the information provided by the clinicians, so we've worked very hard with a number of the groups to improve the information that's provided, but even when that happens, there have been protracted time periods.

Following Christmas, we did see some slippage in our overall response times, and it was related to some challenges in our I&IT system that have been corrected, but the long-term solution—I think what you've correctly identified—is that the process needs to be modernized and be able to benefit from new I&IT systems at the front end that makes the application process for clinicians much easier.

I like to equate it to, for lack of a better, being able to do email ordering, where you have to fill out all of the appropriate information that would allow for a more timely approval process. Similarly, it would give the ability for a looking-in by clinicians or patients to be able to determine where their application is in the process. So we are working forward to that. We are in the process of putting together how we would be able to accomplish that in the coming year.

Mr. Jeff Yurek: It would be nice if somewhere down the line we could have a system where the patient knows that the medication is covered as they leave the doctor's office or specialist's office. Specialists are worse. The patient takes forever to see a specialist, then comes to the pharmacy and the drug's not covered—now what do you do?

Ms. Suzanne McGurn: Understood. Thank you.

Dr. Bob Bell: So much of the time taken in the past, I know, has been taken up by forms going back and forth between the EAP program and the physician who hasn't completed the form appropriately. So to have an automated system that forces clinicians to actually fill in the appropriate slots will be a huge step forward in terms of one-time application.

Mr. Jeff Yurek: Thank you very much. I think that's it for drug coverage.

Minister, just your thoughts, if you can respond: Yesterday, with physician-assisted death now being in Canada, you mentioned doctors being protected from any repercussions from the law. What are your thoughts—or can you speak to pharmacists, nurses and other health care professionals who might be implicated in the treatment of the patient—on the fact there are no protections in place for them?

Hon. Eric Hoskins: That's an incredibly important question you've asked. In this interim period, which we anticipated, we are certainly imploring our federal Senate colleagues—my office has been speaking to some of the Ontario senators, as well, imploring them to pass this legislation quickly—but understanding that it may have to revert to the House of Commons if there are amendments. But we're hoping that this interim period will be short, because the federal legislation specifically explicitly does address the protections necessary that need to be in place for pharmacists and nurse practitioners.

In the absence of that federal legislation, for physicians we have guidelines that have been promulgated by the College of Physicians and Surgeons of Ontario. I know that we, and they, have been working with the Ontario College of Pharmacists, as well as the College of Nurses of Ontario. I'm not aware whether those two entities—I believe they have not published their own guidelines to date. In this interim period, what we have recommended is—you can appreciate that those specialties' professional organizations, as well as the colleges that regulate them and the professionals themselves, are quite anxious to see the federal legislation in place, as are we.

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In the interim period, we have recommended that, including for our physicians—first of all, we've recommended that if an individual is considering medical assistance in dying, a patient, caregiver or family member approach their health care provider. We have also recommended in this interim period that the health care provider—a physician, for example—approach their college—in this case, if it's a physician, the College of Physicians and Surgeons of Ontario—to get further guidance from the college. We're quite gratified that the College of Physicians has spent an enormous amount of time over quite a period of time developing guidelines which provide that guidance for physicians.

To the point: In the absence of federal legislation, we believe it's important that health care providers, as with patients, pursue a court process to be assured that the circumstances are in compliance with the Supreme Court decision. That court process can provide the necessary protections, understanding that if it's in compliance—essentially, the law of the land today is the Supreme Court decision. The Attorney General has spoken to this as recently as yesterday. So that's why we feel that it's not simply prudent but important that that court process be included at this juncture, in the interim period, to provide assurances to everybody that their participation—from the patient himself or herself to the health care professionals who might be involved—is in compliance with the Supreme Court decision.

That being said, I think, in the very short future—I anticipate that we're probably looking at a very short period in terms of days or weeks before that federal legislation would be in place. If it is passed still containing those elements that reference pharmacists and nurse practitioners, the concern that you've raised will no longer exist.

Mr. Jeff Yurek: Thank you. Have you budgeted any costs for the medication to be covered? Are you looking at—

The Acting Chair (Mr. Michael Mantha): Mr. Yurek, you have approximately four minutes left.

Mr. Jeff Yurek: How many?

The Acting Chair (Mr. Michael Mantha): Four minutes left.

Mr. Jeff Yurek: Thank you.

Hon. Eric Hoskins: It went fast.

Mr. Jeff Yurek: It did. You should get Ms. McGurn up there more often.

Are you going to renegotiate the cost of the medication or the price of the medication?

Hon. Eric Hoskins: I'm going to ask Suzanne to answer this, if that's all right.

Ms. Suzanne McGurn: Just to confirm: Pharmacies would have received communication yesterday from the executive officer detailing the drugs that can be used and how the pharmacy would bill for them. Information is included in those about the reimbursement and cost of those drugs.

We are not anticipating the numbers of individuals to be so substantive that an adjustment needs to be made, but we have certainly made sure that we can accommodate, should individuals be approved through the process the minister has outlined—that they will be able to access those medications regardless of whether they are traditionally eligible for Ontario Public Drug Programs. A special program has been established, so financial means will not be a barrier to access.

Mr. Jeff Yurek: Is there a process like the facilitated access system that pharmacies have to call and get an authorization, or can they just bill—

Ms. Suzanne McGurn: No, the information is available for all pharmacists and provides—probably for you, it provides a specific PIN that they would use, and the process for which they can access directly from pharmacy.

Mr. Jeff Yurek: And are the medications available in Canada or Ontario?

Ms. Suzanne McGurn: There are a number of medication regimes that have been suggested, and they are outlined in the information that has been communicated.

There are other medications that individuals may try and access through the Special Access Programme. At this point in time we are unclear of the access to those, but there is a range of combinations that are available in Canada and can be accessed by the pharmacies.

Mr. Jeff Yurek: So is that communiqué sent out on your general email?

Ms. Suzanne McGurn: It is.

Mr. Jeff Yurek: So it's sitting here somewhere.

How many minutes do I have?

The Acting Chair (Mr. Michael Mantha): A minute and a half.

Mr. Jeff Yurek: All right, Minister, you have a minute and a half.

Some 25% of Ontario "doctors say that during the past month, tests or procedures for their patients had to be repeated because results were unavailable." Do you know what the cost is to the system because of having to repeat lab tests? It comes from a Health Quality Ontario report.

Hon. Eric Hoskins: I'm familiar with the report. Thank you for referencing it. It is based on data provided through the Commonwealth Fund, as you know. I found that particular statistic not only curious but worrisome, that it was that high. This is a survey of physicians, so it's subjective to a degree, in the sense that it's asking a question of physicians; it's not based on hard or objective data to verify it. But there's no question that there will be a cost if that figure is any percentage of requiring it to be repeated.

Mr. Jeff Yurek: Could you get me what you would estimate 25% would be, roughly? Not right away, but—

Hon. Eric Hoskins: It was just community labs that it was talking about, so in terms of the cost to the government, our community lab line in the budget is—approximately $600 million?

Dr. Bob Bell: That's correct.

Hon. Eric Hoskins: So it would obviously be a portion of that, if in fact that figure—

Mr. Jeff Yurek: That doesn't break down between hospital lab and community lab, though, right? So it could be—

Hon. Eric Hoskins: Correct. In fact, the hospital line would be separate and in addition to that figure that I gave. But it—

The Vice-Chair (Mr. Michael Mantha): Thank you, Minister. Merci, monsieur Yurek. On va maintenant passer la parole à M^me^ Gélinas du parti NPD.

M^me^ France Gélinas: To finish up with the First Nations: I made a mistake when I was talking about the hospital. It was the Weeneebayko hospital that I was talking about, but I think I said Meno Ya Win. Was your answer for Weeneebayko Area Health Authority, WAHA, for capital planning and a commitment from the province to help this hospital establish longer-term financial stability? You answered for the right hospital, although I think I said the wrong one.

Hon. Dipika Damerla: Yes, I did speak to the right hospital.

M^me^ France Gélinas: Okay, Thank you. I just wanted to check.

This one sort of has to do with First Nations, but has to do with access to care in the north. I wanted to talk about methadone treatment. It is a tough go for people to gain access to those clinics. It is a tough go throughout treatment, and it is even harder to transition off of methadone.

So my first question is, what exists in Ontario right now to help people transition off of methadone? They have not been using, they are taking the treatment, they have a job, they have a family, they want off this whole daily visit and it seems almost impossible to do. I can speak for people in Sudbury in my riding: It is impossible to come off. There is no support. Does that support exist elsewhere? Who funds that, and how do I get one up north?

Hon. Eric Hoskins: I think roughly about 40,000 Ontarians are currently enrolled in programs that provide support for their addictions through methadone treatment. I think you've hit the nail on the head in terms of emphasizing the importance of how it can't simply be a replacement of the opiate with methadone and that's the extent of the therapy that's provided.

What needs to be provided are those supports—clinical, behavioural, community—through the primary care system, the wraparound supports that lead to more than simple replacement, as you've referenced, and actually result in individuals being weaned off the methadone and being given the supports they need to live, hopefully, normal, fruitful lives.

There are jurisdictions around the world and in Canada that have developed approaches—and it exists, to some degree, in Ontario—where there are comprehensive, multidisciplinary environments where methadone treatment is provided with those ancillary support programs that I've referenced are so important, but not to the degree that I would like to see. Other jurisdictions, as I mentioned—particularly in BC, where they have developed approaches, best practices and clinical guidelines that not only provide more comprehensive supports and care, but in fact are looking at a different model of care. For example, jurisdictions in BC include Vancouver Coastal Health authority which is a leader in Suboxone as opposed to methadone as the drug of first choice. It is far, far less toxic and achieves the desired outcomes that are—

M^me^ France Gélinas: I want to stay focused on my question. I have this clinic in Sudbury which consists of telemedicine doctors who we rarely see—mainly guys, a few women—who feel like they are captive. They want to get off of this and there is nowhere for them to turn to be able to wean off or come off.

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I fully understand that to have an interdisciplinary team help you through this would be great. We do have

an aboriginal health access centre. We have a nurse practitioner-led clinic. We have a community health centre in Sudbury. But none of this is connected to the methadone clinic, which continues to be a doc sitting, I think, in London, and who, through telemedicine, gives out those little drinks. That's what we got, and they want off.

Hon. Eric Hoskins: I was getting to that.

M^me^ France Gélinas: Sorry.

Hon. Eric Hoskins: What I was suggesting is that in Ontario we've got an opportunity to dramatically change the model of support that we provide. This would address the issue that you've referenced.

Last fall we made some changes, you'll recall, to the urine drug testing that is conducted in methadone treatment clinics.

M^me^ France Gélinas: You changed the fee code; that's all you changed.

Hon. Eric Hoskins: We changed the fee code, but it helped us understand that there were some unfortunate incentives that ran counter to the efforts that should be made to wean individuals off of methadone—a monthly maintenance fee that we provide to those same methadone clinics as well.

There are different types, right? There are the stand-alone clinics and then there are those that truly are embedded in primary care.

It was as a result of what I began to understand and learn through the changes we made to urine dipstick testing. I asked the ministry—and we've accomplished this—to convene a methadone treatment and services advisory committee. It's essentially a task force that I asked be created to look at specifically how these 40,000-plus individuals in Ontario are being served, and to look around the world, particularly in Canada, particularly in Vancouver, because of the success that they've seen in their best practices in a different model.

This advisory committee has met a number of times. I've participated in a number of those meetings directly myself. In fact, I've asked, as part of this—because I think it's important to be part of a broader opiate strategy as well, but this will form, certainly, part of the foundation of that strategy—for the task force to emerge with recommendations on a model and approach which reflects best practices, appropriate clinical guidelines, as well, on precisely the issue that you've addressed.

I'm extremely uncomfortable about the existence of a methadone treatment entity absent those supports that you've referenced that are so important. I've believe we've got an opportunity. I believe that Suboxone, in part, provides that opportunity where it would increase the level of comfort of family doctors and nurse practitioners, for example, to engage in the delivery of Suboxone as a first treatment, which works in a huge majority of cases, which allows it to be—

M^me^ France Gélinas: Can I have a time frame for when the work of that advisory committee will be done?

Hon. Eric Hoskins: Yes. It would be imminently.

M^me^ France Gélinas: Imminently? Good.

Hon. Eric Hoskins: I'm beginning to receive the recommendations. It's informing the broader strategy that I talked about. I anticipate, subject to going through the normal cabinet process, that I would hope to be able to speak to this issue more specifically in the coming months.

M^me^ France Gélinas: Thank you.

The Acting Chair (Mr. Michael Mantha): On that note, Minister, thank you.

Madame Gélinas, it is now time to recess. We will resume following our regular proceedings.

The committee recessed from 1015 to 1603.

ELECTION OF VICE-CHAIR

The Clerk of the Committee (Mr. Eric Rennie): Good afternoon, honourable members. Due to a change in the membership of the committee this afternoon, as ordered by the House, Miss Taylor has been replaced by Mr. Mantha. Mr. Mantha is the new permanent member of this committee, replacing Miss Taylor.

It is my duty to call upon you to elect a new Vice-Chair, since Miss Taylor was our Vice-Chair. Are there any nominations for Vice-Chair? Madame Gélinas.

M^me^ France Gélinas: I nominate MPP Mantha.

The Clerk of the Committee (Mr. Eric Rennie): Madame Gélinas nominates MPP Mantha. Mr. Mantha, do you accept the nomination?

Mr. Michael Mantha: Yes, I do.

The Clerk of the Committee (Mr. Eric Rennie): Are there any further nominations? Seeing none, I declare the nominations closed and Mr. Mantha elected Vice-Chair of the committee. Mr. Mantha, could you please assume the chair?

Interjections.

The Vice-Chair (Mr. Michael Mantha): I've got the gavel in my hand, so be quiet.

We are now going to resume: Madame Gélinas?

M^me^ France Gélinas: I move that Mr. Mantha replace Miss Taylor on the subcommittee on committee business.

The Vice-Chair (Mr. Michael Mantha): Is there any discussion? Shall the motion carry?

The Clerk of the Committee (Mr. Eric Rennie): Say, "It carries."

The Vice-Chair (Mr. Michael Mantha): I don't want to.

It carries.

MINISTRY OF HEALTH AND LONG-TERM CARE

The Vice-Chair (Mr. Michael Mantha): We are now going to resume consideration of vote 1401 of the estimates of the Ministry of Health and Long-Term Care. There is a total of five hours and 19 minutes remaining. When the committee recessed this morning, the third party had approximately 12 minutes left in their round of questioning.

Madame Gélinas, le plancher est à vous.

Mme France Gélinas: Thank you, Chair.

When we stopped this morning, I was talking about some of the stand-alone methadone programs that exist. I was wondering if we could find out how much money is being spent right now on methadone treatment, either programs or centres, and how much money is being spent on programs that help people transition off of methadone.

Hon. Eric Hoskins: Thank you for that question.

I do have some additional information about our Opioid Agonist Maintenance Program: There are 330 physicians that are providing opioid agonist therapy, either methadone or Suboxone, to a total of just over 50,000 patients in the province. I had thought that is was slightly less than that, but the most current data that we have suggests that it's 50,000, roughly. There's a total of $164 million paid to physicians through that Opioid Agonist Maintenance Program.

Can you refine your question just to sort of help guide me to where your next—

Mme France Gélinas: My next question would have to be: This is for the maintenance program, but how much money is being spent on programs—I use "to wean people off"—to help them transition to a life where they don't need those opioid maintenance programs anymore?

Hon. Eric Hoskins: Well, implicit in this program is that part of the activity that is provided—because you'll see, within that total of $164 million, there are payments for the maintenance of the patients, and there are also ancillary services that are provided that are billed by physicians as part of the program. Implicit in that, and as part of our program, would be services and activities by those physicians themselves—for those where it is an option—to wean patients off and provide the requisite supportive care.

Of course, as well, I know your interest is specifically or more so in the stand-alone clinics. Obviously, the anticipation is that these patients will also have primary care providers that are able to provide them with support. The administration of the methadone may take place in an independent facility, but that doesn't preclude—and, in fact, I think I agree with you, emphasizing the necessity of other activities and supports being in place through the primary care system to wean patients successfully off their methadone.

Mme France Gélinas: Right now, of the $164 million that is paid to physicians for the opioid maintenance program, is there any way to tease out of that how much is really for maintenance and how much is really for coming off that program?

Hon. Eric Hoskins: No, I'm told that there is not, because of the nature of how the service is provided.

Mme France Gélinas: There is not. Okay. That's too bad.

My next question, then, would have to do with the 10 centres that we talked about this morning and that you had announced through the $220 million for First Nations, a good part of that being for primary care with the seven centres in the north and three in the south. Would there be a possibility for those centres to have resources to help people come off methadone and other opioid maintenance programs and live a life free of it all?

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Hon. Eric Hoskins: Absolutely. In fact, I would suggest that some of the best practice of supporting and transitioning individuals who have addictions to opioids—actually, some of the best examples take place with First Nations communities and with First Nations front-line health care workers providing that culturally appropriate care, including the use of Suboxone, I might add.

Just as a reference point, if you'd care to come back to it, remember you asked the question about the fruit and vegetables program and the expansion to on-reserve?

Mme France Gélinas: Yes.

Hon. Eric Hoskins: If you want to come back to that, I have information about the Sudbury area.

Mme France Gélinas: But you're not going to give it to me?

Hon. Eric Hoskins: I don't want to assume that you want it. I just sort of offered—

Mme France Gélinas: Yes, I do want it.

Hon. Eric Hoskins: I didn't want to interrupt the flow. We were doing so well on methadone.

Mme France Gélinas: Okay. We'll flow, and then we'll come back to fruits and vegetables. From methadone to fruits and vegetables: I love it.

Ms. Sharon Lee Smith: My name is Sharon Lee Smith. I'm the associate deputy minister for policy and transformation.

Madame Gélinas, just to add to what Minister Hoskins was saying about the primary care centres and our indigenous action plan announcement, we've already begun working with NAN and some other First Nations communities, and as well, with the AHAC executive directors and CHC directors, to think through how we would better serve communities through a more fundamental approach with Suboxone etc. Attawapiskat, for example, has come to us; they want to have a program.

Your questions are very on point. The communities are asking, and we are embarking on a process to see how we can be as thoughtful as possible about that with the new investments.

Mme France Gélinas: The transitioning off of Suboxone or methadone can be done in the community? It does not have to be done in an in-patient facility?

Hon. Eric Hoskins: Yes. Correct.

Mme France Gélinas: Okay, thank you. Fruits and vegetables.

Hon. Eric Hoskins: Fruits and vegetables: As we referenced—and I think the reference in the press release or the backgrounder probably should have been more explicit in referencing the Sudbury region. In fact, we're referring to the Sudbury and District Health Unit catchment area, so that's likely why there is—I think I can provide the clarity. We were talking about on-reserve schools, elementary schools, that would newly benefit from this expansion. It includes four on-reserve schools

on Manitoulin—which are within the catchment area, of course—one in Massey, and one in Gogama.

M^me^ France Gélinas: It's in Mattagami. Okay, perfect. Thank you.

Hon. Eric Hoskins: Yes, Mattagami. That's right.

M^me^ France Gélinas: Thank you. That's helpful.

My next questions, then, will have to do with—how much time do I have, Speaker, so I use them wisely?

The Vice-Chair (Mr. Michael Mantha): You have approximately five minutes and 20 seconds left.

M^me^ France Gélinas: Okay. I will move on to the Myalgic Encephalomyelitis Association of Ontario, who were really thrilled in 2014 when you announced $560,000—at the time, it was to support two new fellowships over three years, for a total of six fellowships. They were going to be for, basically, family medicine graduates who complete an extra year of focused training in environmental health, which helps primary care providers assess, diagnose and treat environmentally linked health issues. This has been useful, but it's coming to an end. It has been done mainly through the Environmental Health Clinic at Women's College, just across the street here.

My question is, has the $560,000 that was announced all been spent? Is there any intention of continuing that fellowship? How much money would be in that fellowship program?

Ms. Sharon Lee Smith: Sharon Lee Smith, associate deputy for policy and transformation.

Madame Gélinas, we do fund the fellowships, as you were indicating. We do have an environmental task force that we are creating and that will be coming on stream very soon. We will want to review the funding of the important work that the fellowships are carrying out as a part of the task force's work.

M^me^ France Gélinas: Okay. So is there money attached to this task force? I know that there are four people attached to it. I have no idea if they're attached to it for an hour a month or for a full-time or part-time job.

Ms. Sharon Lee Smith: There is administrative funding attached to the task force, but we would obviously consider the recommendations on programming, on initiatives, in terms of what the ministry should be doing going forward.

M^me^ France Gélinas: In this year's budget, is there money allocated for whatever recommendation or work that that committee brings forward, whether it be fellowship or other?

Ms. Sharon Lee Smith: I think we would be looking at anything that the task force would bring forward within our existing envelope. It's very much a priority to make sure that we do hear from the environmental task force.

M^me^ France Gélinas: Okay, so there's no money directly to this, but if they bring forward recommendations that have resources attached to it, you would be open to those?

M^me^ Sharon Lee Smith: C'est vrai, oui.

M^me^ France Gélinas: Okay. Thank you. With my last minute or so—I know that I have talked about the scope of practice of nurse practitioners and the issue of not moving very fast with their scope of practice toward narcotics and toward ultrasound and all the rest. We all know that in the federal bill for medically assisted dying, which I think—

Le Vice-Président (M. Michael Mantha): Une minute, madame Gélinas.

M^me^ France Gélinas: I'm using the wrong name—nurse practitioners will be one of the practitioners who will be able to prescribe those drugs and to carry on the wishes of a patient. Don't you find it weird that they will be allowed to prescribe those drugs but they're not allowed to dipper urine? Shouldn't we move on those faster rather than slower? I'm worried.

Hon. Eric Hoskins: Yes, I do find it weird.

M^me^ France Gélinas: All right.

Hon. Eric Hoskins: In fact, I met this week with the Nurse Practitioners' Association of Ontario to discuss this specific issue, among others. At this point, the College of Nurses of Ontario has been working towards a regulation, because the responsibility is ultimately theirs to develop, pass through their council, post—I might have the order wrong there, but to post and approve a regulation that would enable the prescribing of controlled substances.

Obviously, with the medical assistance in dying legislation close to being passed, which enables nurse practitioners to participate, that creates an even greater urgency. Our approach to this—

The Vice-Chair (Mr. Michael Mantha): Thank you, Minister. We will now move on to the government.

Ms. Indira Naidoo-Harris: Chair, my question is for Minister Hoskins. Minister, as you know, 5% of all our patients account for two thirds of our health care costs. I'm sure you'll agree that's a remarkable statistic and one that underlines the complexity of delivering quality care to Ontarians.

These are most often patients with multiple complex conditions, people who are dealing with not one, not two, but often several health care challenges at the same time. Minister, during my work on Ontario's dementia strategy, I had the honour of speaking frequently with seniors. These are our mothers, our fathers, our friends, our neighbours. These are the people who built our province up and provided us all with a strong foundation on which to stand.

One of the things that became apparent in my many conversations that I had with our seniors about their health needs is that their needs are complex. They need and deserve special care. For example, my 85-year-old father has now moved to Ontario and he is a diabetic. He also has cardiac issues and he has mobility problems. All of these conditions require attention and that means an individual care plan, one that coordinates and plans care, medications and services.

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That's why coordinating care for patients with multiple complex conditions is so important. It's the right plan. It puts patients on the path to wellness. By coordinating care, the patient gets an individualized and

coordinated care plan and support when and where they need it, especially when it comes to all kinds of services and coordinating medications, in addition to a care provider who is familiar with their individual plan.

Minister, in 2012, our government launched the health links as a key initiative to help care for these patients with really complex medical needs. Can you please provide us and provide this committee with an overview, if you will, of health links and how they're working to improve care for Ontarians with complex medical needs? Because this is such an important initiative.

Hon. Eric Hoskins: Absolutely. Director Phil Graham can provide you with that information, as I invite him to enthusiastically. While he's making his way up, I'll just say that there's a tiny proportion of the most complex, complicated patients in the province, for no other reason than just happenstance and bad luck, who find themselves in a position where they absorb and require the support of our health care system to much greater an extent than average Ontarians, if I can call them that, would avail themselves.

One of the breakthroughs that we created, which predates me as health minister, was our health links, which allow a personalized approach, including the development of a care plan—I know that we'll hear some details in a moment—and the wraparound support of primary care providers. It often allows us to look at the social determinants of health, understanding that the complexity that these individuals face is often due to circumstances outside of that direct health care realm, if you will.

We now have I think 80—

Mr. Phil Graham: There are 82.

Hon. Eric Hoskins: —82 health links across the province that have developed a focus not on the entity as much as the leadership that exists in a particular locality. They have then reached out and sought out those specific individuals who would benefit from that focused attention, the development of a care plan and their participation, along with their caregivers if they have them, in the development of that plan as well. Then they assemble the resources that we have in the health care system and, as I've referenced, often beyond, to provide the highest quality of care.

So we've seen the result of that, not simply in terms of improved outcomes but, I think importantly, with regard to the patient experience, as well, and their quality of life. We're able to improve upon what otherwise or previously for them might have been an incomplete sort of support provided to them, or not sufficiently coordinated or holistic to provide the support that they need.

But I'm happy to have Phil, who will introduce himself more fully in a moment, speak more to this important health initiative.

Ms. Indira Naidoo-Harris: Thank you for that. I'm very interested in what you have to say, and especially interested in what you said, Minister, concerning the cocoon of care that surrounds these patients, because I can tell you just from my personal experience that it really does make that patient feel as if their needs are being tended to. That in itself is conducive to wellness and peace of mind, and reduces the stress.

Please go ahead.

Mr. Phil Graham: Thank you for the question. Thank you, Minister. My name is Phil Graham. I'm the director of the primary health care branch in the Ministry of Health and Long-Term Care.

Just following from the discussion, I think I'll start by talking a little bit about the origins of the health links initiative. Like many good programs, this program started with a really solid piece of evidence and Ontario really leading the way in developing the evidence around users of our health care system who rely extensively on a large number of health care resources to get the care they need.

In particular, analysis done by our ministry, in addition to Drs. Walter Wodchis, Peter Austin, David Henry and others, has shown that there is a relatively small segment of our population who relies on extensive medical health care services. These individuals are individuals with COPD or with diabetes, or could also have a physical disability or a serious mental health and addictions challenge and, as the minister said, their individual life circumstance may also be negatively impacting their health and well-being. Understandably, this segment of our population relies extensively on health care services, quite often at a high cost and sometimes with varying levels of quality. In particular, 1% of health care consumers, about 147,000 Ontarians, utilize about 33% of health care service resources; 5% of our population, about 710,000 Ontarians, are responsible for about 65% of health service expenditures. This 1% to 5% of the population is the focus of our health links initiative.

Cost isn't the only way that we measure how our health care system is performing. Evidence from these researchers also suggests that the quality of health care that some of these individuals are receiving in some cases has room for improvement. For example, about three quarters of complex patients 65 years or older were discharged from hospital and saw about six or more different physicians along their care pathway, along with a range of community pharmacists, home care providers and a host of other service providers. We know that sometimes this experience for those complex patients can be confusing and can make it difficult to navigate through the health care system. This is really the problem that the Ontario health links initiative is trying to solve.

As mentioned in the lead-up to your question, the program was developed in December 2012. Just to describe the model very simply, it's a model of person-centred local collaboration that really aims to improve the care at a lower cost for those in Ontario who have the most complex health needs. I'll explain these features a little bit further.

The person-centred element of the program was included very early on in the design. It involves identifying at a local level the patient cohort that will be the focus of health links activities. This identification is not

large percentages or maps or other aggregating tools; this is really about identifying the individual by name, by history, by living circumstance and by what they need. This is done by health care providers in the circle of care to make sure privacy is protected.

They're also very local in nature, and this local dimension of health links is very important. Geographic health link regions have been established at a community level to allow for more focused activities: focus on identifying who these complex patients are, as well as focused collaboration activities within a manageable number of provider groupings. These sub-LHIN regions range from about 40,000 people, total population, for those in rural areas, to about 250,000 for the more densely populated urban areas.

Lastly, a strong feature of health links is collaboration—collaboration within organizations, between organizations and with organizations and individual providers. In many cases, these collaborations and partnerships are quite diverse.

The collaboration really comes to bear, as you mentioned in the lead-up to your question, in the development of a coordinated care plan. The care planning process involves engagement of patients and their families along with a range of providers who are involved in that person's care. They ensure that the individual hospital, the family doctor, the long-term-care home, the community organization and others involved in the care of a complex patient are aware of the medications they're on, when appointments are booked, their living circumstances, as well as their formal and informal caregivers.

What's critical in this care planning process is the role of the patient and the family. They drive the care planning process. Quite often, the experience is that the first question being asked when a coordinated care plan is being developed is, "What do you need?" It is then that the patient can be able to articulate what he or she needs to make sure that the care planning process is responding to their circumstance.

Having described a little bit about health links and their origins, I just want to talk a little bit about what we're seeing now as the program has evolved since 2012. As the minister indicated, we now have 82 health links, from where we started in 2012. At that point, there were about 20 to 26 early adopters that had put themselves forward. Over the last couple of years, we've seen a significant expansion of the program. These 82 health links cover about 89% of the geography of the province. Our goal is full provincial coverage. Ongoing work is happening to make sure that the preconditions are there in regions across the province that aren't yet covered to make sure that we can form health links.

As a result of health links, we now have 14,000 complex patients who have a coordinated care plan like I was just discussing. Each plan is a robust exercise. It's connected through a coordinated care tool, an IT solution, that can bring providers together so that each provider can access the coordinated care plan. We now have 14,000 complex patients who are benefiting from this experience.

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As a result of health links, we're also seeing that 24,000 complex patients have now been attached to a primary care provider. This step is important not only to make sure that complex patients can access the quality treatment and assessment services that primary care providers provide, but also necessary to provide system navigation and access to other forms of care, be it a specialist or community supports.

There are also several local examples of where health links are innovating in the way they deliver and coordinate care for complex patients. In the Champlain LHIN, for example, we see diverse partnerships, including the Ontario Disability Support Program, other local programs, mental health and addictions services, and partnership with community paramedicine.

Central East LHIN, for example, has supported their health links in what's called a hospital-to-home program, which helps patients with mental health and addictions challenges transition from the hospital to the community.

In Chatham-Kent, for example, the Chatham-Kent Health Link is using live data feeds between the hospital and primary care providers to let primary care providers know in a timely way when complex patients are admitted or discharged from hospital. It's really an innovative way of how a health link is leveraging current technologies to be able to support complex patients and provide care closer to where they live.

Although we know that health links take time to mature and to operate at scale, from the data we see significant progress being made. Patient experience measures, for example, across all health links are extremely positive. As the minister was saying, these positive experiences can be directly attributed to the health links activities that are happening across the province.

We also know from preliminary utilization data—data that shows how health care services are being accessed and used—that we're also seeing some progress. For example, the North Simcoe Muskoka health links, who place considerable emphasis on their complex mental health and addictions patients, have reported a 57% reduction in ER visits for this small cohort of patients and a 43% decrease in patients' length of stay in the hospital.

Similarly, the North York Central Health Link, who are focusing on a cohort of complex patients with mental health and addictions challenges, saw a 47% reduction in emergency department visits for this cohort, and a 62% reduction in hospital admissions.

As this work progresses, and with the help of leading researchers and practitioners in Ontario, we're undertaking various forms of formal evaluation to measure the impact and outcomes across the board that these health links are achieving. This will be broad in terms of the quality of care and the patient experience, as well as the cost.

In the meantime, we're also partnering with Health Quality Ontario, our lead quality agency in the province, to help share best practices and promising practices, so

we can learn from the examples and great work of one health link and apply them in other communities across the province.

We're learning a lot from health links, both in terms of the value they bring to the system and the value they bring to complex patients across the province. We're looking to adapt these more broadly as we carry out further reforms and further mature our health links. As I said, early evidence is showing that these health links are demonstrating considerable progress, and we're going to continue to support them as this work continues.

We just recently received a report from a health link identifying a very compelling personal story about how the intervention of one health link helped a family who experienced the loss of a loved one, along with job insecurity, income insecurity and food insecurity issues. The story was compelling because it shows not only that health links are a core health care program, but also the bridges they build between health care and other sectors.

Through a health link's intervention, not only was this health link able to attach this individual family with quality primary care, but it was also able to connect this family with local job- and employment-seeking services, a local church group who were donating physical activity supplies and bikes for the children who needed this help, and the Boys and Girls Club, to make sure the family had the support they needed.

That's really where the power of health links comes in. As the program matures, we are seeing broader connections not just within health care but between health care, social services and community supports.

The Vice-Chair (Mr. Michael Mantha): Madam Naidoo-Harris, you have three minutes left.

Ms. Indira Naidoo-Harris: Three minutes? Okay, great. Thank you very much for that very detailed answer.

Would it be accurate to say that before health links came along, a number of patients out there were perhaps lost in the system, trying to navigate it on their own and unsure about what directions they were going in, and now that health links are around, this is really helping them coordinate and navigate and find their way through the system? Is that accurate?

Dr. Bob Bell: Thank you for that. One of the things we've learned from health links has of course contributed to the minister's approach on Patients First, and that is the importance, as you're describing it, of care coordination. One of the really intriguing aspects of Patients First is extending the scope of care coordination for home care to all home and community care services in the sense that the home care coordinators could be dealing with all the navigation issues that you're describing.

We find that one of the most important aspects of health links is that patients with complex conditions who are having difficulty navigating and who previously would have had no assistance in navigating between multiple medical specialists or other social resources available to them are now able to work through the system far more smoothly, including important social aspects like transportation, for example, or access to nutrition supports, as Phil has described.

One of the really intriguing aspects is the way this has extended to community policing as well because, of course, some folks with mental health problems, with addiction issues, are frequently visiting our emergency departments and our court systems. What we've discovered—starting in Waterloo, actually, where community policing got involved with the health links program—was that by bringing patients who had these kinds of complex problems to an interdisciplinary table where their problems could be addressed by stable housing from the municipality, perhaps MCYS services, CAS services for their children, stable provision of primary care providers, or social workers in the community who would help them with a variety of different issues, not only could we decrease their reliance on emergency departments but also keep them out of the court system and keep them out of policing attention as well. So we're discovering—and this has spread.

This innovation, which originally started in Scotland, spread to Saskatchewan and Waterloo and is now becoming increasingly prevalent across Ontario: the so-called hot-spotting of individuals who are using a variety of social services, including health services, putting comprehensive care plans around them that involve social aspects as well as health aspects.

Ms. Indira Naidoo-Harris: Do you find that health links are really highlighting that connection between social determinants and good health?

Dr. Bob Bell: Yes, that's an excellent way of describing it—the fact that simply dealing with health aspects without looking at employment and without looking at social assistance and housing, really, is less than a comprehensive answer to a complex care problem that needs more than simply health solutions.

Le Vice-Président (M. Michael Mantha): Merci, Docteur Bell. Merci, madame Naidoo-Harris. On va passer la parole à M. Bill Walker des conservateurs.

Mr. Bill Walker: Thank you, Mr. Vice-Chair, and congratulations on your recent appointment.

I'm going to start off, if I could, by asking the minister—although I told him I'll be very brief with him today—a couple of quick questions.

This one, Minister, I'm asking on behalf of a lot of people in my riding and across the province. It's one of the most consistent messages I get asked when I'm out in the community: How much is your government currently spending on the ads promoting your health care successes, the concern being that all that money could be going to front-line care that they're not getting in many cases? Do you have a dollar value that you're spending on these ads that are currently running in that regard?

Hon. Eric Hoskins: We may have that. I don't have that at hand right now. Over the course—perhaps I might get some assistance with this—of a year we invest a considerable amount of funds that are geared towards the various formats of communicating with the general public on a variety of issues, for example, directing them

to government websites which will provide them with information on how to find a care provider or the health care services that are available in their neighbourhoods. There's a whole suite of activities that we undertake. The investing in health care advertising campaign, specifically, which I believe is the one that you're referencing, uses radio and community newspaper ads to help Ontarians understand that the government is making significant new investments in the health system.

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Mr. Bill Walker: Just the dollar value, if I could, Minister.

Hon. Eric Hoskins: The dollar value of the total budget for the campaign is $2.6 million.

Mr. Bill Walker: The concern I have is that I think if they were being directed to some services, it would be more helpful. Most of it is talking about how wonderful things are and how great the services are. That's not what I'm hearing, so the concern that I get almost every day in my office is, "Why is the government continuing to spend money talking about how wonderful they are, rather than actually giving me the services, so that I could tell them how wonderful they are if I could get them?"

The other question I have is with regard to your Patients First plan, and very specifically to the rolling-in of the CCACs to the LHINs. Can you tell me how much money is actually going to be saved by doing this transaction and, obviously, how much is going to the front-line care and how quickly that will happen?

Hon. Eric Hoskins: Well, of course the legislation was just introduced, so it hasn't yet been passed. This is obviously provisional on the legislation being passed by the Legislature. As yet, we haven't defined a specific dollar value. Our priority in making this transition is to ensure that, in as seamless a fashion as possible in the first instance, those responsibilities that are currently carried out by the CCACs migrate across to the LHINs.

Under direction from me, the ministry knows, and it's their intent as well, that there are functions that are currently being undertaken by both entities, our LHINs and our CCACs—administrative functions, for example, and other activities. There will be, through this process, identification of where they are duplicative in nature.

Additionally, the proposal is that many of the functions that are currently undertaken by each individual CCAC, of which there are 14, and by each individual LHIN, of which there are 14—that makes 28 separate activities on the administrative side. There are a number of back-end functions—IT, payroll, human resources etc.—and the proposal is that those activities, which are currently spread out and quite separate among 28 separate entities, will be merged into a single entity. We're confident that significant savings will be found there as well.

Mr. Bill Walker: But what's the estimated—I keep coming back to this each time I come to estimates. I built a house. I asked my contractor how much the plumbing would be, how much the heating would be, how much this is. I want an estimate so I know and then I can choose what I'm going to do and how much I can afford. I continually come to estimates and you never give me numbers. If you're assuming that you're going to do this for the benefit of people and there's going to be a savings that you can then put back in, at least give me some basic numbers.

My concern is that you have a majority government. It's not going to take that long to get through. At least give me an estimate of what the savings are going to be, so that I can tell the people in my riding and across this great province how much more money is going into front-line care as a result of this. A very specific question is: Can you assure me there will be no severances where then that person is hired back the next day with the new organization? Because we know that's happened in the past.

Hon. Eric Hoskins: Yes, I can provide you with that assurance today.

Mr. Bill Walker: Thank you very much.

Hon. Eric Hoskins: I know that it's very important to Ontarians that, with this transformation, which is about, in part, saving funds and redirecting them to front-line care—we've learned from the Auditor General's report and the report that preceded it from Gail Donner, for example, which pointed to improvements in efficiencies that could be found.

However, there's a process under way. I think you can appreciate that although we've done considerable planning and consultation, we need to couple the overreaching goal of transferring without any impact on patient care. There are more than, I think, 700,000 Ontarians who benefit from home care each year. We have to combine that with a very direct intent to provide efficiencies and reduce, in some cases.

I think the deputy was just indicating that the total amount for all 14 CCACs for management and executive is in the order of $70 million. We believe that we can find savings within that, as well as what I previously referenced in terms of administrative—

Mr. Bill Walker: Percentage of savings, dollar value of savings?

Hon. Eric Hoskins: Well, it's difficult—

Mr. Bill Walker: Target? Accountability?

Hon. Eric Hoskins: I guess the way I've characterized this with the ministry in terms of my expectations is I believe, and I agree with an expectation by Ontarians, that they should anticipate that there will be significant savings that will all be redirected to and reinvested in front-line care. But coming up with an approximation or a dollar value of what that might be I think is something that I would simply suggest is going to take some time, as we have just in the past week introduced the legislation. It is a transformation that's going to take place over the course of months and indeed, in some respects, more than a year.

Mr. Bill Walker: So next year, I'll come back and ask you what the savings were. Thank you very much, Minister—

Hon. Eric Hoskins: Well, we'll certainly be a lot closer. And I—

Mr. Bill Walker: One last question.

Hon. Eric Hoskins: Okay. I would enjoy the opportunity—you can deny it to me, but I know the way you characterized the expenditure by the ministry on advertisements. I actually feel that informing the public that, for the first time in a number of years, we're making a multi-million dollar, $345-million investment in our hospitals is important information, particularly in the context of some of the other discussions that are taking place out there—

Mr. Bill Walker: I think there's a lot of free social media that we could utilize, and those dollars could go into actual patient care. I don't hear people saying, "I don't know how well the government is doing." People ask me, "Why can't I get this service?"

Hon. Eric Hoskins: But that's why I also think it's important that Ontarians need to know that 700 net new physicians began practising in the province over the course of the last year. As we're at 94% attachment of Ontarians to a primary care provider—and we're aspiring to provide either a family doctor or a nurse practitioner to everyone who desires one—I think it's important that there's an understanding out there that, in fact, we are making those gains and we are hiring more physicians to be able to address that need.

Mr. Bill Walker: I'm just feeding back what my constituents are telling me, Minister.

Hon. Eric Hoskins: No, fair enough.

Mr. Bill Walker: A very specific one, if you could. The infrastructure budget: You're talking about $160 billion that you've now put over 12 years. Can you tell me the percentage of the budget that's going to be allocated to seniors in long-term care—just a number, a percentage?

Hon. Eric Hoskins: The figure that you referenced I think was for all of government. The infrastructure investment through the Ministry of Health and Long-Term Care is $12 billion over 10 years.

Do you want to tackle that?

Mr. Bill Walker: Thank you. That's a good segue, because I think your associate minister has been feeling a little deprived by not getting the spotlight. As I'm the critic, I want to do my best to shine the light on her and ask her a few questions so that she has an ability to shine in front of all of us.

Hon. Dipika Damerla: You're so kind, MPP Walker.

Mr. Bill Walker: I'm not going to ask this question; I'm just going to put it on the record so that we can make sure we know.

Your government originally committed 35,000 beds for long-term care in 2003. Then you went and changed the commitment to 30,000 beds. You're now suggesting about 5,000 have been built, which—okay, we're there. I don't want an answer now because that will just eat up my time, but I want to still have a copy of the plan of how many beds, where they're going to be built and when they're going to be built by. We'll just park that one, if I could, respectfully, because I have asked you that numerous times, but I want it on the record one more time.

How much have you committed to adding new long-term-care beds, how much will it cost to add the new beds, and again, when and where? We've talked about redevelopment, but what about new beds?

Hon. Dipika Damerla: Did you still want me to respond to your first question?

Mr. Bill Walker: No. For the first one, I'll just wait, because I know you're working on that plan. But the secondary is the new beds. We've been talking about redevelopment—just new beds. So how much have you committed, when and where?

Hon. Dipika Damerla: As you know, we've already introduced—brought online—10,000 new beds since 2003. We'll be happy to share some examples of that, if you will indulge me, with some of those new beds that we—

Mr. Bill Walker: I don't want to hear about what you've done, I want to hear about what you're going to do.

Hon. Dipika Damerla: All right.

I think it's really instructive to also look at what we've done because that gives you an indication of what we're going to do, because we always build on—

Mr. Bill Walker: I'll hear that in the radio ads. Just tell me what you're going to do, please.

Hon. Dipika Damerla: MPP Walker, let me finish.

In terms of what we are going to do, we have, as you know, been working on a capacity plan. It's a province-wide capacity plan. One of the things that I emphasized when I spoke in response to MPP Gélinas as well is we can't fixate on one sector of eldercare. Long-term care is one piece of the continuum of care that we provide to our seniors and, for that matter, all Ontarians. You have to take into consideration the increased investments in home care, because every time we add an extra dollar to home care, we are potentially taking away the requirement to build another bed. We have to take into consideration that there is a continuum of care.

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I think the right question to ask, MPP Walker, if I might, would have been, "What are you doing in terms of eldercare?" as opposed to one piece of it.

But since you have asked about the capacity planning, what I can tell you is that we have opened over 10,000 new long-term-care beds and redeveloped 13,500 long-term-care beds since 2003, including more than 900 redeveloped and new beds since January 1, 2015.

We've created 250 more short-stay beds in long-term-care homes, that provide care to people who need time to recover strength, endurance and functioning before returning to the community.

All of this is to say that we've brought some new beds online. We're working on a capacity plan that's looking at how many more beds we need, not only today but into the future: over the next 10 years, over the next 15 years. That's a plan that is really coming to fruition quite quickly. We hope to be able to announce more and tell

you more about that as soon as we work through that plan.

Mr. Bill Walker: You've segued into a good place, Minister, because back in 2006, the government expert panel report on ALC noted that every day in Ontario, more than 1,600 acute-care beds are occupied by ALC patients. In 2016, we've had an update of that.

There were 22 recommendations that were made in 2006. So when you talk to me about planning, I don't think many Ontarians expect not to see action over 10 years. Planning and planning and planning and planning—it's not deliverables. That's what I hear, again, at the front line and in our offices. I'm sure that you hear them in your office. That's what people want to see. They don't want to hear about more plans. They want to hear about, "Why can't my mom or my dad, or my uncle or my aunt, get a bed when they need it?"

There were 22 recommendations made by that expert panel and provided to your ministry. Can you tell me how many recommendations the ministry took action on?

Hon. Dipika Damerla: What I can tell you—and I take some exception to the characterization that over the past decade, over the past 10 years, we've only been planning, because, as I've said, we've added 10,000 new beds since 2003. Over the last 13 years, we've added 10,000 new beds, so we have brought new beds online.

I'm conceding the point that we may need to add more. What we are doing right now, and we're really at the tail end of that, is the capacity planning. I'm sure you would agree that you wouldn't want us, without any evidence, to just come up with numbers.

What we are following is an evidence-based procedure. Very robust, province-wide capacity planning has taken place. We look forward to being able to announce more and give more details on our plan. We've added 10,000 new beds, and we look forward to being able to talk more about the next phase.

Mr. Bill Walker: Minister, you originally said 35,000 new beds, then 30,000—fair enough. You're quite proud of the 10,000. It's great to have 10,000. But are you proud that that's 30% of your goal? Or did you really have factual numbers from estimates?

Again, I go back to my analogy of building a house. Either I'm going to spend $200,000 on a house or I'm not going to spend $200,000 on a house.

I get confused with you at times, because you're proud of the 10,000, which is only 30% of your goal. Did you really have true, concrete numbers, or did you pull a number out of the air? Should it have been 10,000? That's what I'm asking you. Then you could say, "I've done 100%, not 30%."

I'm not certain that Ontarians are going to give you a passing grade for suggesting that you're happy about getting 30% of the objective completed.

Hon. Dipika Damerla: Actually, if I may—

The Vice-Chair (Mr. Michael Mantha): Mr. Walker, you have five minutes left.

Mr. Bill Walker: Thank you, Mr. Chair. That's flying.

Hon. Dipika Damerla: If I may, MPP Walker, I need to clarify, because I think there is a difference in understanding, on your part, as to what we are saying.

The 35,000 redevelopment that you're talking about is the existing footprint. It has absolutely nothing to do with the 10,000 beds that came online. They're two parallel tracks for two very different things.

What we said was that we would redevelop 35,000 beds—the existing footprint; the older set of long-term-care beds. Of those 35,000, 5,000 have already been done. We announced phase 2 of it in October 2014, which is the enhanced redevelopment. Through that, I'm proud to say, we have now about 1,000 beds in the new phase 2 that are ready for redevelopment and have been approved for redevelopment.

Completely separate from this 35,000 original—5,000 done; 30,000 left; another 1,000 of the 30,000 done, so essentially, 29,000 more beds to be redeveloped, per our target—

Mr. Bill Walker: I keep coming back to the plan for those 29,000: when and where and how much?

Hon. Dipika Damerla: I'd be happy to answer that once you let me finish answering this one.

Completely separate from that is the addition of 10,000 new beds. You really need to unpack the two. One is new footprint that we've added since 2003; the other is redeveloping an existing footprint of 30,000 beds that may have been built in the 1970s, 1980s or 1990s. I hope you're clear on that.

Mr. Bill Walker: So you've got two separate piles. You've unpacked it. I've got all that. Why won't you give the plan of when and where if you know all of this stuff?

Hon. Dipika Damerla: I just told you, and I'm happy to actually go through some of the redevelopments that we've already announced. I've just told—

Mr. Bill Walker: No, I don't want to hear the redevelopments. I want to hear where your plan is for going forward. Why can't you give me a plan that tells me—

Hon. Dipika Damerla: I am giving you a plan.

Mr. Bill Walker: —how many beds you're going to build in 2016, 2017 and 2018? There are a lot of people who aren't getting long-term-care beds who are in a hospital, which is our most costly form of health care, because they can't get into that long-term-care facility. You haven't yet, in the numerous times I've asked you, given me the plan of how many more beds are going to be built this year and where.

Hon. Dipika Damerla: Are you talking redevelopment or are you talking new footprint?

Mr. Bill Walker: You can give me both numbers, redeveloped and new. I think you've addressed that there's a need for both, so what are those needs? Give me the total number of beds and where you're going to build them and when.

Hon. Dipika Damerla: Okay. I just told you, and I'm going to repeat it, this year, say from January, we have

announced 1,000 beds for redevelopment. We have approved them.

Mr. Bill Walker: Where?

Hon. Dipika Damerla: Let me give you the list, because—

Mr. Bill Walker: Excellent. We're making progress.

Hon. Dipika Damerla: —the last time I was trying to, you interrupted me. On April 4, 2016, in the city of Stouffville: 112 beds. Of that, we have approved 31 beds for redevelopment. At Faith Manor—that was on April 7, 2016, in the city of Brampton—we announced 120 beds being redeveloped.

Mr. Bill Walker: Minister, if you'll indulge me, you can pass me that on a piece of paper and I can read that. Can I ask you another question now?

You're talking about 1,000 beds. There are 25,000 people on a waiting list. What I want to address for the people of Ontario is, what are you doing to address the 25,000-bed waiting list?

Hon. Dipika Damerla: What we are doing is that we have brought online 10,000 new beds, as you know, and we have invested more in home care. That is very critical. Every time we invest more in home care, it takes pressure off that wait-list, because what Ontarians have told us loud and clear is that if they can, they would rather be in their own homes than be in a long-term-care home.

Mr. Bill Walker: Some can be in their own homes, absolutely. Keeping people home is a wonderful initiative and we all support that, but not for the people who need a long-term-care facility.

Hon. Dipika Damerla: I understand that.

The Vice-Chair (Mr. Michael Mantha): Can I just jump in, members? Can you try and not talk over each other, so that you can share the information so that the rest of the committee can benefit from the information?

Mr. Bill Walker: Certainly, Mr. Chair.

The Vice-Chair (Mr. Michael Mantha): Go ahead. Finish.

Hon. Dipika Damerla: So—sorry, I lost my train of thought. What I was saying was that you have to recognize our investments in community care, because they're a crucial part of addressing that wait-list issue. We have come a long way in addressing that wait-list issue. In fact, wait times are down compared to four years ago. So that's really critical.

Then the third piece is, indeed, our capacity plan, which is going to look at if we need new beds going forward. If we need new beds, where do we need these new beds? How many of them do we need? What kind do we need?

I have told you that we are at the tail end of that kind of analysis and we look forward to coming forward with a plan on that. There are really three parts to this plan: redevelop the existing footprint, invest more in community care, and then a robust, evidence-based plan on what we need to do in terms of adding capacity.

The Vice-Chair (Mr. Michael Mantha): On that note, thank you, Associate Minister.

On va maintenant passer la parole à M^me^ Gélinas pour le parti NPD.

M^me^ France Gélinas: Merci, monsieur Mantha.

I am drilling down a bit on the question. Remember, I was at the 10,000-foot level. I'm now on ground level.

We've talked about the public dental program, mainly for children. Now I would like to know if there is any money whatsoever in last year's or this year's budget for adults with dental needs. We know that we have 61,000 visits a year to emergency rooms for dental programs. That's every nine minutes. We know that we have 200,000 visits to physicians' offices for dental programs, but very low public dental programs. There's one in Peel, actually, with a wait-list of 24 months. Is there any money at all for dental programs for adults? I'm expecting a number.

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Mr. Patrick Dicerni: My name is Patrick Dicerni. I'm the assistant deputy minister of our strategy and policy division at the Ministry of Health and Long-Term Care.

Thank you for the question, Madame Gélinas. Broadly speaking, the initiative that that would fall into is our low-income health benefit. That is a piece of work that my division, at the request of the minister and the deputy, is working on, but there isn't money that we have identified in this year's current budget that we would implement in an encompassing low-income health benefit.

M^me^ France Gélinas: You don't have a forecast for the next year, by any chance? Can you give me hope, or is there no hope in sight?

Mr. Patrick Dicerni: I could give you some hope on the basis that we are actively developing what elements of a low-income health benefit would be, but we're not at the point of articulating or communicating what a potential allocation or spend would be against what could be multiple elements of a low-income health benefit, including access to adult dental care.

M^me^ France Gélinas: Are there any external stakeholders who sit at that table you're referring to?

Mr. Patrick Dicerni: Right now this is internal ministry policy work. We're working with our other ministerial colleagues, including the Ministry of Community and Social Services and the Ministry of Finance.

Hon. Eric Hoskins: You are probably aware, as well, that in my mandate letter—in terms of giving you hope—it specifically references looking at the potential for a sustainable low-income health benefit as part of my mandate.

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

I'm jumping around. Again, we have looked at return of service before. This time I would really like to focus on—that was a program that was in place from 2000 to 2008, and it was basically a return of service, mainly family physicians who would go back, become specialists and return to service in underserviced areas, which is what I represent.

I know that many of them never did their return of service. I'm wondering if you are still collecting from

that group, and if you can show me how much money is being collected from that group; that is, the group from the years 2000 to 2008. It was actually Minister Smitherman who was the lead on that at the time. Is there any way to find out how much money we're collecting from those people who never returned, as well as how many physician specialists we are talking about who did that program but never did their return-of-service obligation?

Hon. Eric Hoskins: I believe we have some additional information that we can share with you in that regard.

Ms. Denise Cole: Hi. I'm Denise Cole, the assistant deputy minister for health workforce planning and regulatory affairs with the Ministry of Health.

Madame Gélinas, as you know, there are a number of components to the return-of-service program. The one that you had asked about in the last session was the re-entry return-of-service program. That was the two-year one. Is that the one you're referencing?

M^me^ France Gélinas: That's the one I referenced way back. Now it's the one that was from 2000 to 2008. It went on for about eight years, and it was for family physicians who would go on to take four to five years' training—that would bring them to 2013—and never came back to the north to do their return of service.

Ms. Denise Cole: That is the general return-of-service agreement program. That is still an ongoing program. To give you the numbers on that one, since 2003:

—approximately 2,900 individuals have signed an ROS agreement;

—820 successfully completed their five-year ROS obligations;

—630 of those 2,900 are currently returning to service as qualified physicians in an eligible community within Ontario;

—1,270 of those are completing their residency training, and that ranges anywhere from two to seven years; and

—170 are not fulfilling their ROS obligation, out of 2,900.

As of May 2016, of the 170 who did not fulfill their obligation, approximately 50 have repaid an estimated $5 million towards their training costs, so therefore they have been released from their obligation. The remaining 120 we continue to pursue for potential repayment.

M^me^ France Gélinas: How hopeful are you that if 50 of them give us $5 million—I'm strong in math—120 of them would give us $12 million? How hopeful are you that we will get that $12 million?

Ms. Denise Cole: We are. We first try to do our internal work. We do this in partnership with HealthForce Ontario. Then we refer it to the Ministry of Finance, and then we go to a private collection agency to try to pursue the outstanding debt. But we pursue as much as we can, and we are actually working on revising the policy around when a loan can be forgiven, because there really shouldn't be any circumstances under which we are forgiving any loans.

How hopeful are we? I can't specifically answer that. How determined are we and how dogged are we? We are.

Hon. Eric Hoskins: Can I also, if you'll allow me, put it into context? Of the 2,900, those figures demonstrate that roughly 50% have either completed their return of service or are completing it; about 40%, I believe, are undergoing and continue to undergo residency training; and less than 5% are in that position where we are pursuing them for lack of completion of the ROS obligation.

Ms. Denise Cole: Actually, it's 4.43% that haven't fulfilled.

M^me^ France Gélinas: Okay. If you look through the books, do they show right now as a $12-million recoverable, or do you put it at a lower amount?

Ms. Denise Cole: I don't have that specific number, because it varies depending on the program that the individual is in, but I can follow up and get you the actual number that the 120 represent.

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

Ms. Denise Cole: You're welcome.

M^me^ France Gélinas: I'm jumping to long-term care. Is there an increase to the food per diem in this budget for long-term-care homes? Right now, it's at $8.03.

Hon. Dipika Damerla: Indeed, there is. We can get you some more detail—

M^me^ France Gélinas: Either the percentage or what it will come to this year.

Hon. Dipika Damerla: Yes, we can share that with you.

M^me^ France Gélinas: All right. Is there an increase in the "other accommodation" line in the per diem, and what will that be?

Hon. Dipika Damerla: As you know, a portion of the "other accommodation" is funded by copay, a big portion of that. We can get you numbers on the ministry's portion of the OA and what that would be like.

M^me^ France Gélinas: Is the copay going up?

Hon. Dipika Damerla: The copay is not going up, other than the standard inflationary adjustment.

M^me^ France Gélinas: Okay. What was the standard inflationary adjustment at this year?

Hon. Dipika Damerla: I believe it was—was it 1.5% or 1.3%, the inflationary adjustment?

Dr. Bob Bell: It's CPI.

Hon. Dipika Damerla: It's just what the CPI is. It's the CPI; we can get you the CPI number.

M^me^ France Gélinas: Okay, so the copayment will go up. How much the ministry will pay in the "other accommodation" line, you will give me the difference, as well as how much the food per diem will go up? You will give me those numbers?

Hon. Dipika Damerla: Yes.

M^me^ France Gélinas: Okay. I see somebody behind you.

Interjections.

M^me^ France Gélinas: So it's coming, or it's not?

Hon. Dipika Damerla: We'll endeavour to get you what we can, MPP Gélinas.

M^me^ France Gélinas: Okay. The next one has to do with the Health Infrastructure Renewal Fund. I've asked

some questions about this, but I'm still not clear. Since the community health centres became eligible for assistance from the Health Infrastructure Renewal Fund, has this fund been increased as a result of the inclusion of the CHCs? And I'm between two now: Is there any intention of putting long-term-care homes as eligible for the Health Infrastructure Renewal Fund?

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Hon. Dipika Damerla: It's really important that conceptually, long-term-care homes are not funded as a capital asset, because the province doesn't own the long-term-care home. It's owned by the municipality, the for-profit or the not-for-profit. What we do is provide a construction funding subsidy over a period of the licence, which could be 25 to 30 years. It's funded from the operating budgets, and that's—

M^me^ France Gélinas: I'm fully aware. I'm just asking you if you had looked at funding this differently for not-for-profit homes.

Hon. Dipika Damerla: From an accounting perspective, it would not make sense to fund it from a capital budget when the ownership lies somewhere else. This is actually a more efficient way from how we are spending government funds—

M^me^ France Gélinas: So the answer is no? I'm okay with this. I'm not arguing what we're doing now. I just want to ask the question and have you on the record.

Dr. Bob Bell: Madame Gélinas, you were asking a question about the CHC and the Community Capital Fund.

M^me^ France Gélinas: Yes.

Dr. Bob Bell: Mr. Kaftarian could describe that.

Mr. Peter Kaftarian: I'm Peter Kaftarian. I'm the executive director of the health capital division in the Ministry of Health.

For community infrastructure, this year we rolled out a community infrastructure fund. We did a survey with community providers last fall, and we are just in the process of rolling out the fund this year, to target for community providers for minor infrastructure renewal things, similar to the kinds of things that HIRF does but focused specifically on community.

M^me^ France Gélinas: Okay, but is this a fund different from the Health Infrastructure Renewal Fund, where a community health centre can now apply to?

Mr. Peter Kaftarian: Yes, it is different.

M^me^ France Gélinas: It is different.

Mr. Peter Kaftarian: Yes.

M^me^ France Gélinas: So how much money are we talking about?

Mr. Peter Kaftarian: For this year, the approach we're piloting is $5 million.

M^me^ France Gélinas: Wow. When will you roll this out?

Mr. Peter Kaftarian: We're in the process of rolling it out right now. Through the survey that was released last fall and the information we gathered, we were able to run it through some criteria in order to allocate, by LHIN, an estimated amount of funding that could be provided for these types of maintenance projects. The applications were to be submitted to us for assessment. We're in the process of reviewing those applications that have been submitted.

M^me^ France Gélinas: The fund will be called the community infrastructure fund, and it will be separate from the Health Infrastructure Renewal Fund?

Mr. Peter Kaftarian: Correct. Just a point of clarity: The HIRF program is the hospital infrastructure renewal fund. That is specifically for hospitals. That program has grown from $56 million to $175 million since 2014. We've significantly increased the investment in that program.

M^me^ France Gélinas: Okay, but I thought that since community health centres became eligible for assistance from the hospital infrastructure renewal fund, it was called the Health Infrastructure Renewal Fund. I dreamed that up?

Mr. Peter Kaftarian: It's a separate fund.

M^me^ France Gélinas: It's a separate fund.

Mr. Peter Kaftarian: Yes. CHCs, for example, can also submit applications for community infrastructure funding. So, for example, if a CHC wants to expand their program—if they're delivering more services—they can put an application in through the LHIN for consideration, through our community fund. But this community infrastructure fund is specifically targeted to—like, you've got basic maintenance things you need to do within accessibility requirements, and you may need to put basic maintenance in, not program-based applications.

M^me^ France Gélinas: All right. I'm still confused. The community infrastructure fund is for maintenance for community-based health agencies.

Mr. Peter Kaftarian: Correct.

M^me^ France Gélinas: And what you call the hospital infrastructure renewal fund is solely for hospitals?

Mr. Peter Kaftarian: Correct.

Dr. Bob Bell: We've got a HIRF and CIRF.

M^me^ France Gélinas: Oh. Okay.

Le Vice-Président (M. Mantha): Madame Gélinas, il vous reste cinq minutes.

M^me^ France Gélinas: He's stressing me. I'll move on, then.

Back to hospitals, but this time it's more operational: We have the 1% base funding increase for hospitals, and the 1.1% funding for post-construction operating funds for provincial priority programs. How do I find out where this money has gone and where this money will go, per hospital, per LHIN? Do you have a nice big chart for me?

Dr. Bob Bell: We do. We do have a big chart.

M^me^ France Gélinas: I would not want you to read that big chart, but I would want you to share that big chart. Is that okay?

Dr. Bob Bell: We can certainly look into that, Madame Gélinas.

M^me^ France Gélinas: That's not a yes.

Hon. Eric Hoskins: Do you mind repeating your question in terms of specifically what information you're looking for? We might be able to glean it from—

Mme France Gélinas: I'm looking for, per LHIN, per hospital, the amount of money that the government is going to share with each hospital, through their LHINs, on the base funding increase and the additional 1.1% funding.

But I'm also interested in all the other funding envelopes, whether they will be the ambulance offload delays, the pay-for-performance emergencies—all of the others.

Dr. Bob Bell: If I may, Minister, the various headings that go into comprising a total estimate of hospital funding include the base funding from 2015-16 and the overall increase in the base hospital funding investment, the overall increase related to their HBAM investment, the health-based allocation, the 2015-16 hospital base funding, pressure funding, as well as renewed base funding based on one-time funding. So a variety of different headings go into the calculation of the $345 million of increased funding, including, as you've described, the PCOP funding.

We'll certainly see if we can make all this available to you.

Mme France Gélinas: And will it come up to the amount that we use in the House all the time, the three hundred and—

Dr. Bob Bell: Forty-five, yes.

Mme France Gélinas: It will come up to that?

Dr. Bob Bell: Yes.

Mme France Gélinas: Okay. The more headings, the better. I like the big chart. Thank you.

Do we keep track of the number of RNs, RPNs and PSWs who work in our hospitals, either by hours worked, full-time equivalent or anything of the sort?

Dr. Bob Bell: We do have the total information for the province based on the College of Nurses of Ontario, based on RNs and RPNs, the numbers that are registered in the province and the numbers that are working in hospitals. We have that information. PSWs—I don't think we have that information.

Interjections.

Dr. Bob Bell: I'm confirming from Denise—why don't you come and sit with us, Denise? There's probably another question to follow. We do know the number of RNs and RPNs working in hospitals.

Mme France Gélinas: Okay. So we would know through the college if they indicate, but they very well may work in the hospitals; they may work for a CCAC; they may do private nursing. When you renew your licence, you identify to your college where you work, but you may work at more than one. If I'm interested in looking at it through the view of our hospitals, as in how many hours of those different professions, do we keep track of that? Or do we only have the data coming from the college?

Dr. Bob Bell: The CIHI data relates to nursing. I'm not sure we split it out into RN and RPN.

Ms. Denise Cole: Actually, the CIHI report—they do their calculation a bit differently. What CIHI does is report on the primary employment. Although they look at their source, or the numbers from the College of Nurses, the way they do their calculation is, they segregate the data a bit differently, where they would look at the primary employment.

Mme France Gélinas: Okay.

The Vice-Chair (Mr. Michael Mantha): On that note, thank you, Ms. Cole.

Merci, madame Gélinas. C'est le temps de passer la parole aux libéraux : Mme Naidoo-Harris.

Ms. Indira Naidoo-Harris: Merci beaucoup. Minister Hoskins, my question is for you. We all know that primary health care providers are essential allies in health care delivery. In fact, you may say that they're the front line when it comes to providing the vital care that people need when they need to get well.

Timely access to primary care is the key to keeping Ontarians healthy. If people can quickly access their family health care provider when they need assistance, it can prevent them from becoming sicker and requiring more acute and costly levels of care. In fact, access to care where and when people need it can actually help patients avoid a visit, for example, to the emergency room and can prevent conditions from becoming worse. That's why providing care where and when people need it is a pillar of our Patients First strategy.

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Timely access allows patients and providers to better manage chronic diseases like diabetes and cancer, and by doing so, patients avoid crowded wait rooms and get better faster. Access to quality primary care expediently is a key pillar of health care in our province. When people can have their ongoing health care needs met close to home, illnesses, as we all know, can be better managed.

Minister, can you please provide this committee with an update on just what exactly the ministry is doing to enhance primary care in Ontario? And if you can please shed some light on some of the new initiatives that will improve primary health care delivery.

Hon. Eric Hoskins: Certainly. I'm going to make some remarks but I'm also going to ask Director Graham to join me because he can go deeper into this extremely important issue, which, quite frankly, is one of the foundational pieces of our Patients First approach to the delivery of health services.

You referenced timely access, for example to a primary care provider. That measurement is really more of an output than an outcome. It doesn't necessarily guarantee improved health but it certainly is a gateway to that. And it's an indicator that's very important to Ontarians as well. We've seen that through surveys and interacting with patients and Ontarians: that their ability to access their primary care provider is an important indicator for them with regard to their ability to maintain or improve their own health. It's one area where we're working very hard to continue to improve that access. There are certain models of care which are aimed to further enable that timely access which is so important.

Even though we're talking about primary care, it's something that obviously needs to and should extend to access to specialists as well.

It's an important area, and there's no question that there is more work to be done. In some respects it's a bit counterintuitive, but there was a recent study done that indicated—it might have been CIHI; I'm not sure—that the best primary care providers in terms of providing that access are fee-for-service doctors in the province. There is room to grow and improve among our family health teams.

It's not a challenge that's unique necessarily to Ontario, but it is one of many indicators. It is a fundamental principle—that principle of access. Whether you measure that in terms of the percentage of Ontarians who are attached to a primary care provider—I know we all default to the family doc, but it can also be other health care providers, including nurse practitioners. We have 25 nurse-practitioner-led clinics in the province that are functioning exceptionally well. In fact, when you look at satisfaction surveys from patients and clients, among the highest—if not the highest—in the province generally tend to gravitate towards our nurse-practitioner-led clinics. There's a tremendously high level of satisfaction with regard to how patients view their ability to access and the care that they receive. So it's important that we look at the full spectrum.

Patients First, in a general—hopefully not over-simplified—sense, really is aiming to turn the lens around. Where we so often look at the delivery of health services down the lens of the programs that we provide or the various silos of the health care system or a hospital environment or home care or long-term care, this turns it around. The person who's looking down the lens is not the health care provider; it's the patient. What is the patient's perspective in terms of what their experience should be and how we can improve that experience?

That's really the focus of Patients First: to imagine, from the patient's perspective, how we can provide a more coordinated health care experience where we can reduce wait times and improve access, where we can improve the overall quality so that patient experience is higher and where we can better integrate all the different pieces of health care, including primary care.

I'm going to ask Phil to expand on this because this is an area for which not only is he responsible but he's particularly talented in.

Ms. Indira Naidoo-Harris: It's really just about customer service, isn't it, in some ways, putting that lens on it when we're looking at the patient.

Hon. Eric Hoskins: Yes. It's not particular to government, but I think that if more of us thought about our role as, in part, delivering the best possible customer service that we can, that helps us understand that lens that we should be looking at things through—and understanding that the health care system isn't the government's health care system; it actually belongs to and is owned by the people of this province. So we continually need to rethink how we're delivering those services in a way that does provide the highest quality of care, measured not necessarily by us, measured scientifically and objectively of course, but measured in terms of the patient experience.

Ms. Indira Naidoo-Harris: Almost a living entity.

Mr. Phil Graham: Thank you, Minister, and thank you for the question.

I think it's important to revisit, in the lead-up to your question, what you're talking about in terms of the important role that primary care plays, not only in the health and well-being of Ontarians but in terms of the overall functioning of the health care system. It's important just definitionally, to describe primary care as simply the entry point to the health care system. It is, for most Ontarians, the first point of access, not only in seeking care directly but also in accessing other parts of the health care system and, increasingly, other parts of the social services system as well. In addition to referrals to specialists for surgical procedures, primary care providers are increasingly playing a role in helping their patients navigate to community support services and other services that they rely on.

We know, through evidence, that how a primary care sector performs actually has an influence on how the broader health care system is performing. Foundational researchers such as Barbara Starfield have demonstrated that jurisdictions that have a strong foundation of primary care actually are associated with better health equity as well as overall better system performance.

In Ontario, when it comes to primary care, I think it's fair to say that we've come a long way. There have been 10 to 15 years of reform in Ontario's primary care sector, and I think it's safe to say that how Ontario's primary care sector looks today is quite different than how it looked over a decade ago.

One of the features of the reform that we've gone through has been changes to physician practice models, and these have been well documented. Up until about the early 2000s, the majority of family physicians—about 90%—practised by themselves in a solo-practice model where their compensation was provided solely on a fee-for-service basis. As the minister alluded to, this model does have its benefits, but it was shown at that time that it was not meeting the needs of all Ontario's patients, or meeting the needs of providers.

New practice models were introduced beginning in the mid-2000s. The new practice models have many features. One of them is that they have physicians working in groups, or group practice models. These group practice models really help to ensure that physicians are less isolated in their practice, particularly in the northern and rural areas, where there could be far distances between them and their colleagues. It also helps them to leverage the skills of colleagues within their practice setting to improve the care that patients are getting. One physician may have a particular specialty in palliative care and others in geriatrics. Having these groups work together to improve care for patients is one of the ideas behind the group practice models. The group practice model helps to improve access to some degree, where physicians connected through a secure electronic medical record can cover each other off when a particular physician may be out of the practice.

Another feature of the new practice model that has been introduced is around comprehensive care. Comprehensive care promotes a broader range of services that include disease prevention, health promotion and chronic disease management as well as other services. At the time, it was seen that this comprehensive suite of services were more appropriate to meet the needs of an aging population. It broadens the focus in these practice models from the treatment of a particular ailment or the treatment of a particular disease to the more holistic care of a patient. Payment out of these models was certainly aligned to address the goal of comprehensiveness.

An important feature of these models that have been introduced is also a voluntary patient enrolment process. This really speaks to the heart of good-quality primary care, which is the importance of that clinician-patient relationship: this notion that there needs to be trust involved so that the patient knows that their provider is aware of their health condition but also their family history, their living circumstance and equally that the physician is familiar with the needs of that patient. So this voluntary patient enrolment process really formalizes that relationship between a clinician and their patient and is a strong feature of these models.

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We started off in the early 2000s with about 90% of physicians and the majority of Ontarians seeking care in the solo-type practice model. Over time, we've seen 9,000 family physicians join these models and about 10.5 million patients formally enrol in these models. So there's considerable progress in moving from this sector that was primarily focused on solo-physician practices with sometimes loose affiliation between the clinician and their patient to comprehensive care with a lot more of a formalized relationship.

Another key feature of the reform that we've gone through over the past decade has been the introduction of interprofessional and team-based primary care. These are really delivered through four main models of interprofessional teams. The four are: aboriginal health access centres or AHACs, community health centres or CHCs, family health teams, what we call FHTs, as well as nurse-practitioner-led clinics or NPLCs.

Basically these organizations bring together a range of professionals and deliver services and programs that are needed by the patient population or the community they're serving. In total, they're just shy of about 300 of these organizations and, collectively, they're serving about four million Ontarians.

What makes these models unique is that they include such a broad range of professions and professionals who deliver services and programs as part of a team. They can leverage the expertise of mental health counsellors, psychologists, traditional healers, social workers, dietitians, pharmacists, registered nurses, registered practical nurses, nurse practitioners, along with physicians, to deliver these patient and community-based programs.

There are many ways that we've seen, through evaluations and reviews of their reports, that these interprofessional teams are really changing the primary care landscape in Ontario. One is around access. We know that these interprofessional teams have actually attached about 900,000 Ontarians who previously did not have a family health care provider.

Also, they're looking at ways of improving different types of access, for example, through house calls. Many of these primary care teams are delivering models of home-based care to make sure seniors and those with mobility challenges don't have to come to the clinic to seek their primary care services.

We're also seeing innovations in terms of the question you asked around same-day, next-day access: these clinics tweaking their practices to be able to accommodate patients who are seeking a service on the same day or next day.

We also see, increasingly, these teams leverage technology to offer appointment reminders through email; the opportunity for patients to book an appointment online as opposed to having to call into their busy clinic, and examples like that.

We also know that these teams are making considerable advances in quality and quality improvement. In partnership with Health Quality Ontario, HQO, all of these nearly 300 teams are submitting annual quality improvement plans, or QIPs. Quality improvement plans have some core measures that all of these teams are identifying where they're at and what they're doing to improve upon.

The three measures for the primary care teams are timely access through same-day, next-day appointments; timely appointments post-hospital discharge as a way of continuing to improve the collaboration they have with their community hospitals; as well as measures of patient experience and the extent to which these teams are acting on patients' experience as derived through regular patient experience surveys.

The quality improvement plans that are developed and tracked annually by these teams are publicly reported on the Health Quality Ontario website. So teams and their patients can continue to look at how they're improving year over year on these dimensions of quality.

We also know that one of the strong points that these teams are really leading on is collaboration and partnership with community partners in the delivery of the services and programs that they're working on. For example, one team we know has partnered with their local municipality to prescribe gym memberships as part of their health and wellness program. A patient comes in, they're seen as benefiting from increased physical activity, and that patient would receive a prescription to a discounted gym membership that the municipality has contributed to, where a dietitian or a health promoter can work with that patient to make sure that they're getting the physical activity and other supports that they need to improve their health and well-being.

Le Vice-Président (M. Michael Mantha): Madame Naidoo-Harris, vous avez quatre minutes qui restent.

Ms. Indira Naidoo-Harris: Sorry?

The Vice-Chair (Mr. Michael Mantha): You have four minutes left.

Ms. Indira Naidoo-Harris: Oh, thank you.

Mr. Phil Graham: Shall I continue? Yes? Okay.

Another team, as a part of the example of collaboration, serves the urban aboriginal population in a northern Ontario community and partners with a local community service agency to arrange for transportation to and from primary care appointments and specialist appointments as well. There are several other examples of how these teams are advancing partnership and collaboration.

We also know that many of these interprofessional teams are really addressing some health equity concerns that are experienced in their communities. I think that community health centres, in particular, and our Aboriginal Health Access Centres are showing tremendous leadership in this regard, where they're providing specialized programs and services to First Nations communities, to those in homeless shelters and to others who traditionally have barriers to access. For example, particular programs are offered in CHCs and some family health teams to special religious groups, such as the Mennonite population.

In the case of Aboriginal Health Access Centres, a very unique model in Ontario, a very unique model, actually, nation-wide: Our AHACs are serving about 93,000 First Nation and indigenous clients. They have a very unique model of care where they bring to bear spiritual, emotional, physical and mental health programs catered to the needs of the populations they're serving.

Now to things that we are doing proactively, building on this progress: We know, for example, as the minister indicated earlier, that we have 94% of Ontarians who now report having regular access to a primary care provider. It's an increase of about 1.4 million from the surveys that we did over a decade ago. We're continuing to improve on how primary care is responding to the needs of those individuals.

In the 2016 budget, for example, there was an announcement for $1.3 million to support our aboriginal health access centres. That $1.3 million we're currently implementing to improve how they're able to assess the degree to which they are responding to the needs of their clients. It's really an analytics- and decision-support-based initiative to equip aboriginal health access centres with the data and analytics capacity that they need to evaluate and monitor the impacts that their programs are having.

We've worked quite closely with a sector that has historically reported challenges in doing this. Although they have modern electronic medical records where they can input the date, their ability to actually glean the most benefit from that data has been limited. So there is some ongoing work to work with our aboriginal health access centre partners to implement processes and to provide them resources to build on that capacity, so they'll be able to better report and better understand the impact their programs are having.

Ms. Indira Naidoo-Harris: Can I ask you if aboriginal health access centres are leading to greater use of these centres? Is there an increase in traffic to them, from what you can tell?

Mr. Phil Graham: We have seen a steady increase in the number of clients served by the aboriginal health access centres, yes. That continues to increase. It's not just for core primary care services. What's unique about the aboriginal health access centres is that they deliver such a broad range of services and programs. Spiritual healing and traditional healing is one of those programs.

So it is unique, and we see a growing volume, but not only for basic treatment services and basic assessments that most folks will go to their primary care provider for. It's for these other add-on services, as well: transportation services, social service supports as well as programs that—

The Vice-Chair (Mr. Michael Mantha): And on that note, thank you, Mr. Graham.

Merci, madame Naidoo-Harris. On va passer la parole à M. Jeff Yurek du parti d'opposition.

Mr. Jeff Yurek: Merci. Thanks. I'm just going to ask a few questions. Then my colleague Bill will come back in.

I asked the question earlier this morning about medically assisted dying with regard to medication lists. I called area pharmacies in my area, and nobody knew about the list. But thankfully, I tracked down OPA, and they found the list that was introduced yesterday via the Drug Benefit Program.

It has a list of the kits and the PIN numbers and it has maximum reimbursement amount. Could we break down how you came to that amount that would be reimbursed? My understanding is that there's no fee or markup allowed; it's just going to be acquisition cost. If you can break down those amounts for me, how you got to these numbers—for the intravenous IV kit with supplies, maximum reimbursement amount is $325; back-up kit, $325; kit with phenobarb and supplies, $999; and there are a couple more here—how you achieved that number, break it down for me, and then I have another follow-up question on this.

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Dr. Bob Bell: If I may, Minister? Thanks, Mr. Yurek. We're checking on all those individual medications that you mentioned. Our drug branch is just going to determine exactly what the breakdown is between the drug cost, the overhead cost and the dispensing cost, and we'll give you that information in a couple of minutes, if we could.

Mr. Jeff Yurek: Okay. Yes, that would be great, to break that down for me.

Maybe you can answer this question while looking that up. Seeing how you've published what the maximum cost will be, what have you put in place to ensure that the wholesalers supplying these medications don't sell them for more than the maximum cost you're willing to pay pharmacies for dispensing?

Dr. Bob Bell: Again, we will get the answer for that for you from our drug program. Here, the answer may be arriving—

Ms. Suzanne McGurn: I am here.

The PINs that have been made up include drug cost, markup and a fee per drug. To your question about the

wholesalers, the distribution of drugs in this province, as you know, is facilitated through wholesalers. Our ministry does not intervene in that chain. I certainly would hope that the industry itself would not be using the opportunity of medically assisted dying for markups. We will certainly be watching to see if we hear of any such activity.

With regard to the products, this is early experience, and we will continue to look at other combinations that may be needed. We have communicated to our health professional colleagues that, should there be other combinations of drugs identified in the future, we certainly would not limit them to just the ones that have been included.

I apologize. I'm Suzanne McGurn, ADM of public drug programs.

Mr. Jeff Yurek: So you've provided for more than just the cost of the medication? Because my concern is that wholesalers will take advantage of the situation and adjust their prices.

Ms. Suzanne McGurn: Thank you for flagging it. We will continue to monitor for that. The sector is quite vocal, and I'm sure I will hear from them should they start seeing behaviour such as you describe.

Mr. Jeff Yurek: Good. Thank you.

I have one other question, just a general one, with regard to internal auditing of the Ministry of Health. Have you allotted more funding to increase the internal audit function, seeing how there's been a lot of wasteful spending with CCACs, and previously with eHealth and Ornge? But with regard to the transition, you're undertaking to ensure that we're keeping our money in check as we transition and there's not wasteful spending, and there are more internal audits going on, going forward—and if there's been an increase in funding to deal with that?

Dr. Bob Bell: Mr. Mike Weir is our chief administrative officer and ADM. Mike?

Mr. Mike Weir: Thank you. The internal audit budget—

The Vice-Chair (Mr. Michael Mantha): Can you please introduce yourself for the record?

Mr. Mike Weir: Oh, thank you. The deputy, I thought, just did it. My name is Mike Weir. I'm the assistant deputy minister for corporate services at the Ministry of Health.

The Vice-Chair (Mr. Michael Mantha): Thank you.

Mr. Mike Weir: If one of my guys could just find the number—what I want to tell you is that our internal audit budget does fluctuate year over year, depending on the size of our audit plan and depending on the priorities that we have. I think I answered a question from you on day one or day two with respect to the interim actuals versus what the estimates were for 2016-17. My answer was that we're building our audit plan now for 2016-17, and the internal audit staff are actually staff of the Treasury Board Secretariat. Once our audit plan is built, we will get a chargeback from the Treasury Board Secretariat, which will pay for our internal audit.

Mr. Jeff Yurek: Thank you. Bill?

Mr. Bill Walker: I will start off with the associate minister. Minister, of the $70,180,700 investment into long-term-care homes on page 144 of the estimates book, how much will actually go to growing capacity?

Hon. Dipika Damerla: Sorry, can we just look at—what page did you say?

Mr. Bill Walker: Page 144.

Dr. Bob Bell: That's the incremental amount, $70 million.

Mr. Bill Walker: Yes.

Hon. Dipika Damerla: You're talking about how much will go to what, sorry?

Mr. Bill Walker: How much going into long-term-care homes will go into growing capacity? What percentage of that $70 million is specifically directed there?

Hon. Dipika Damerla: The entire $70 million will go to increasing their operating funding.

Mr. Bill Walker: Their operating funding.

Hon. Dipika Damerla: Yes—all long-term-care homes that will see an increase to their funding.

Mr. Bill Walker: Can you be more specific?

Hon. Dipika Damerla: I can be specific. What we are saying is that we are growing the pie by 2% for funding, the operating funding. It's nothing to do with new beds. For the existing footprint, we are increasing the funding pie by 2%.

How much each long-term-care home in that pie, what percentage of that they get, is also a function of their case mix index, which changes from year to year. What I can assure you of is that generally, across the system, we are increasing funding by 2%, and what a particular individual long-term-care home might get would be a function, of course, of the increase, but also their case mix index.

Mr. Bill Walker: Can you give me any kind of a sense of what the overall increase to their actual operating budgets is? If we look at the Green Energy Act, since 2007-08, hydro has doubled and tripled. That 2% is probably not even keeping pace with just the energy cost increase. How do you only give them 2% if you know that the actual increase is more than that?

Hon. Dipika Damerla: The way we have increased—the 2% increase is a combination of looking at the real increase in acuity as well as some function of inflation. We crunched the numbers and we looked at it, and that's how we arrived at that.

Mr. Bill Walker: And are you looking at all—one of the things I hear from the operators is on the flexibility of where they actually utilize the envelopes of money. They sometimes are very restrictive and there are very specific settings for how they can best use the money allotted for the front-line care. Can you elaborate on that a little bit, on where you're actually willing to be flexible and give them more flexibility to do it?

Hon. Dipika Damerla: I am going to agree with you that the long-term care act is fairly prescriptive. One of the reasons we are prescriptive in terms of how we would like operators to spend the money is to make sure that the money is spent where it ought to be. If we are giving money for raw food or we are giving money for their

nursing needs, we want to make sure that that money goes there. I think it's a good way.

Within the envelope, there is obviously some flexibility. Homes also get from the province—they can get topped up, based on their case mix index or if they have—there's a pot of money that is for if they have certain residents who might need extra care over and above what's required. So we do look at that acuity piece to fund them. But in general, I am quite comfortable in being prescriptive and sweatering the four envelopes that we do, because that gives us assurance that homes are spending the money where it ought to be spent and that money isn't being taken from one pot to be spent elsewhere, and care might suffer.

Mr. Bill Walker: Are you suggesting, though, that if a home comes to you and can prove to you that they need that flexibility, even though the current legislation is very prescriptive and doesn't allow them, you would be willing to take a look at that and provide some assurance that they can actually do that? Because at the end of the day, it's all about the patient. I get that you want to have some accountability for them, but what I'm hearing from them is that in many cases, it's actually not getting to the resident. It's not actually being able to be increased for better care, because it's too prescriptive.

Hon. Dipika Damerla: I'm going to disagree with that. I think what we have done—we have a really good system where we have some flexibility within the four envelopes, but they are the four main envelopes that we fund. You're probably familiar with them, but they're nursing and personal care, programming and support services, raw food, and other accommodation. I want to make sure that if you're funding nursing and personal care, that money is spent on that and it's not going to other accommodation or to pay for property taxes or something. I want to make sure that the money we have set aside for their nursing care goes to nursing care.

We have a very sophisticated system of capturing the complexity of resident care that each long-term-care home has. Our funding is quite tailored to the case mix index of that long-term-care home.

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So we do spend a lot of time trying to work with the long-term-care home to see what is the kind of funding they need. Once we settle on that, then I think we have a good system to ensure that the money is sweatered.

Mr. Bill Walker: Thank you. Switching gears a little bit, besides the $10 million committed in the budget, how much of the $44 million in annual base funding for Behavioural Supports Ontario is allocated to help long-term-care residents?

Hon. Dipika Damerla: This question has already been asked by MPP Yurek. We said that we would try and get him those numbers, and we still intend to try—and get you the numbers as well, now.

Mr. Bill Walker: Can you give me any kind of a sense of when we might expect those answers?

Hon. Dipika Damerla: We'll try our best to get you the answers.

Mr. Bill Walker: Can you tell me a time frame? Because I might be here in 10 years; I may not be here in 10 years. I think Mr. Yurek is hopeful that it's not going to be a 10-year period.

Hon. Dipika Damerla: We will try and get you the numbers as and when we are able to do that.

Mr. Bill Walker: Would you commit to a 30-day period, which is fairly graceful?

Hon. Dipika Damerla: I believe that under the committee's rules, and I'd like to ask the Chair to rule on that—

The Vice-Chair (Mr. Michael Mantha): Mr. Walker, I think you've received a response. I think it would be efficient for you to make good use of your time and move on with your questions.

Hon. Dipika Damerla: Thank you, Chair.

Mr. Bill Walker: In 2016-17, CCAC funding increased by more than $135 million. Last year, the Auditor General wrote an entire report about how inefficient the community care access centres are. Could you explain why agencies that operate with 39% of their budget going toward administration costs should receive a 5.1% funding increase?

Hon. Eric Hoskins: I'll begin by saying that over the course of the last year—and I'll be brief; don't worry—we've benefited from three important reports—the Gail Donner report on home and community care, as well as the two Auditor General reports—and they identified for us that there needed to be transformational change in the way home care is delivered in this province.

Included in that percentage that you referenced, which was the AG's percentage, was a significant allocation that goes towards care coordinators within the CCAC system. I think it's important—and I think that, largely, we would agree—that care coordinators probably should not be characterized as administrative overhead. They fulfill an important function. That being said, there's no question that efficiencies can and need to be found. The basis for the transformation that has been laid out in the Patients First Act in front of the Legislature is to create that transformation. That being said, the number of clients across Ontario being seen by our CCACs continues to increase. I think, in terms of contacts—they may not all end in actual delivery of services—we're up to about 800,000 across the province on an annual basis. That number, for obvious reasons, is increasing, and it's important that we address that.

Also, it's important to reflect on what Gail Donner said. Her famously oft-repeated quote, as least from me, is, "Form follows function." What's in Patients First, in the proposed legislation, is the form: the governance, the structure. But the function she outlined led to myself—last April, I believe—introducing a 10-point action plan that focuses on function and how we can improve the delivery and enhance the delivery. There was a substantial cost to those 10 points, and it included everything from increasing nursing hours to the PSW wage enhancement as well—which is included in that increase, towards home and community care—to efforts under way

for additional caregiver support, including respite. So there are elements of both, on the form and the function.

We're making the changes in structure and governance, but we need to continue to invest in those important issues, to improve the experience.

The Vice-Chair (Mr. Michael Mantha): Mr. Walker, you have five minutes left.

Mr. Bill Walker: Thank you.

Minister, if I'm hearing you correctly, you're actually setting targets. You're expecting deliverables in those very specific ones that you've identified and, I trust, others.

Hon. Eric Hoskins: Yes—

Mr. Bill Walker: That's one of the things that, again, as the opposition, I think our job is to understand where are you going, what is the plan. It's why I keep going back to the number of beds that you said you would build, and why I can't get a very simplistic black-and-white. So in this case, I think I'm hearing you say—

Hon. Eric Hoskins: We have a number of performance indicators already in place. We're developing more, and we're finding the ones we have. Measuring the success of what we do is vitally important.

One of my frustrations, when I began to look at home and community care—or the home care services and the services provided with CCACs—is the potential for tremendous variability of the services delivered. You could have two individuals who have essentially the same health care challenges and would be assessed as such, in a similar fashion, but they may actually receive significantly different levels of care, depending on where they reside in the province. I wasn't prepared to accept that.

One of the important functions that we're carrying out—again, part of that 10-point action plan—is to actually create levels of service, to create a uniformity across the province, and in a transparent and accountable way, so that an individual, whether they are a caregiver or a client themselves, based on the very objective assessment that is done of them, will be able to ascertain what they should be able to expect from the government with regard to home care, whether they live in the northern part of the province or the southwest or the east—regardless of that.

Mr. Bill Walker: Or the great riding of Bruce–Grey–Owen Sound—

Hon. Eric Hoskins: Or the great riding of Owen Sound.

Mr. Bill Walker: —where we're getting that new hospital in Markdale very shortly.

It has come to our attention that hospital employees are stripped of their benefits at the age of 70. As all of us know, Minister, this is the time when they're likely to begin to need to use them most. Can you give me an idea—I trust this was a cost-saving measure; I'm not certain if that's the case—of what type of money you actually save by that reduction at 70?

Hon. Eric Hoskins: Sorry. I missed the very first part—

Mr. Bill Walker: Employees from the hospital are stripped of their benefits at the age of 70.

Hon. Eric Hoskins: Do you want to speak to this?

Dr. Bob Bell: I think I don't have any—do we have any information on that, Nancy?

Interjections.

Mr. Bill Walker: I don't have a lot, either. Again, it was from a constituent, just saying, "I'm one of those people. That's when I'm going to need my benefits." It seems kind of ironic that that's when they get stripped of them.

Hon. Eric Hoskins: This is something that I'd very much like to bring back to the committee, because it's a very important point that you raise. I'm told by officials that that's not something we are aware of. I'm assuming that you don't have further information or a specific locality that we could reference. Then we could try to ascertain the truth behind that.

Mr. Bill Walker: Sure.

Dr. Bob Bell: In terms of their retirement benefits, some of that may relate to the hospitals of Ontario pension plan policy. I think it actually stops people paying retirement contributions past the age of 65. But we'll check and see what the other benefits are related to.

Mr. Bill Walker: Okay, thank you.

A fairly specific one: Could the minister please explain the $49.7-million cut to the modernization of health human resources and nursing initiatives, on page 84?

The Vice-Chair (Mr. Michael Mantha): In about a minute and a half would be nice.

Hon. Eric Hoskins: If Denise can get up here before I can actually get the answer—

Ms. Denise Cole: That reduction, MPP Walker, pertains to the Nursing Graduate Guarantee program. We have been doing some program redesign based on some evaluation that was done over the life of the program. What we have seen over the last few years is a reduction in the uptake in the program, so that's where the reduction is, in terms of the new graduate guarantee program.

Mr. Bill Walker: Great. Thank you.

Hon. Eric Hoskins: To some degree, this is a reflection of the success itself of the program in one of the very few jurisdictions around the world that does deliver such a program. Nearly half a billion dollars has been invested in it so far, and we've seen the results, including the increase in full-time employment by nurses, in an absolute sense, by about 14%—a 30% increase compared to before in numbers, but as a percentage increase, a significant increase in full-time employment.

Mr. Bill Walker: Okay. Thank you.

The Vice-Chair (Mr. Michael Mantha): Thank you, Minister. Thank you, Mr. Walker.

It being so close to the 6 o'clock hour, this committee will stand adjourned until routine proceedings tomorrow, where Madame Gélinas can start fresh.

The committee adjourned at 1800.

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Tuesday 7 June 2016

STANDING COMMITTEE ON ESTIMATES

Chair / Présidente
Ms. Cheri DiNovo (Parkdale–High Park ND)

Vice-Chair / Vice-Président
Mr. Michael Mantha (Algoma–Manitoulin ND)

Mr. Grant Crack (Glengarry–Prescott–Russell L)
Ms. Cheri DiNovo (Parkdale–High Park ND)
Mr. Han Dong (Trinity–Spadina L)
Mr. Michael Harris (Kitchener–Conestoga PC)
Ms. Sophie Kiwala (Kingston and the Islands / Kingston et les Îles L)
Mr. Michael Mantha (Algoma–Manitoulin ND)
Mr. Arthur Potts (Beaches–East York L)
Mr. Todd Smith (Prince Edward–Hastings PC)
Mr. Glenn Thibeault (Sudbury L)

Substitutions / Membres remplaçants
M^me^ France Gélinas (Nickel Belt ND)
Mr. John Fraser (Ottawa South L)
Ms. Indira Naidoo-Harris (Halton L)

Also taking part / Autres participants et participantes
Mr. Bill Walker (Bruce–Grey–Owen Sound PC)
Mr. Jeff Yurek (Elgin–Middlesex–London PC)

Clerk / Greffier
Mr. Eric Rennie

Staff / Personnel
Ms. Heather Webb, research officer,
Research Services