ISSN 1181-6465

Legislative Assembly
of Ontario

First Session, 41st Parliament

Assemblée législative
de l'Ontario

Première session, 41e législature

Official Report of Debates (Hansard)

Tuesday 31 May 2016

Journal des débats (Hansard)

Mardi 31 mai 2016

Standing Committee on Estimates

Ministry of Health
and Long-Term Care

Comité permanent des budgets des dépenses

Ministère de la Santé
et des Soins de longue durée

Chair: Cheri DiNovo
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111 Wellesley Street West, Queen's Park
Toronto ON M7A 1A2
Telephone 416-325-7400; fax 416-325-7430
Published by the Legislative Assembly of Ontario

Service du Journal des débats et d'interprétation
Salle 500, aile ouest, Édifice du Parlement
111, rue Wellesley ouest, Queen's Park
Toronto ON M7A 1A2
Téléphone, 416-325-7400; télécopieur, 416-325-7430
Publié par l'Assemblée législative de l'Ontario

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON ESTIMATES

COMITÉ PERMANENT DES BUDGETS DES DÉPENSES

Tuesday 31 May 2016

Mardi 31 mai 2016

The committee met at 0900 in room 151.

MINISTRY OF HEALTH AND LONG-TERM CARE

The Chair (Ms. Cheri DiNovo): Good morning, everyone. We're 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 11 hours and 45 minutes remaining.

Before we resume consideration of the estimates, if there are any inquiries from the previous meetings that the minister or ministry have responses to, perhaps the information can be distributed by the Clerk at the beginning, in order to assist the members with any further questions. Is there anything like that, Minister? Anything to be distributed? No? Okay.

When the committee adjourned on May 11, the official opposition had 11 minutes and 30 seconds left in their round of questions. Mr. Yurek, the floor is yours.

Mr. Jeff Yurek: Thank you very much, Chair. Good morning.

Hon. Eric Hoskins: Good morning.

Mr. Jeff Yurek: I guess my colleague Bill Walker had left off asking a bit about the Assistive Devices Program, so I'll just finish up his line of questioning here. I asked you a question in the Legislature regarding diabetic foot ulcers and how people are needing to have an amputation without the proper wound care and prevention. The Premier's report was tabled in 2012 to deal with ensuring that those with wounds are treated with the top level of care and best-practice guidelines.

From the Canadian Diabetes Association: Diabetic foot ulcers cost the health care system between $320 million and $400 million and, in indirect costs, between $35 million and $60 million, yet the offloading devices, which could yield a savings of between $48 million and $75 million, are taking a long time to get enacted. Could you give us a timeline, or explain why it took so long to act on getting these offloading devices covered for people with diabetic foot ulcers, and perhaps give us an outline of how much money is going to be spent on this program?

Hon. Eric Hoskins: Thank you for the question. The issue of diabetic wound care is an extremely important one, as you can imagine, as you've referenced, including the issue of offloading devices. We have asked HQO, because I think it's important to follow best practices and clinical guidelines and develop a uniform approach across the province. In this particular case, it's extremely valuable in the context of home and community care as well.

With our partners, like RNAO and like Wound Care Canada—I think that is how they refer to themselves—we are developing best practices, generally speaking with regard to wound care management of diabetic patients, but specifically, as well, on the issue of offload devices. We expect that in the coming short while, I would expect in the next two or three months—is that probably a reasonable time frame?

Dr. Bob Bell: Yes.

Hon. Eric Hoskins: —that we will have the advice from the HQO-generated table that has that broad participation that I think is necessary to reach the right conclusions. Then, ADP will be looking at that based on the recommendations of that table, assuming that they recommend its provision, and that will be something that we'll be looking at in the context of ADP.

Mr. Jeff Yurek: Do you have a budget and time frame?

Dr. Bob Bell: Can I just add to that, Minister? You asked about—

The Chair (Ms. Cheri DiNovo): Excuse me, Dr. Bell. If you could just say who you are before you begin speaking? Thank you.

Dr. Bob Bell: Sure, sorry. Deputy Minister Bob Bell.

Mr. Yurek, you asked about offload devices specifically. We've started a health technology assessment of the role of various offload devices, initially looking at total contact casting, but now also looking at irremovable air casting devices and—you're quite right—looking at how that could build into the diabetic program within our ADP program.

Mr. Jeff Yurek: Do you have an estimate at all on what you would budget toward covering it? Is there going to be an increase to ADP's overall budget or will it just be part of the package when it's added in?

Hon. Eric Hoskins: Well, at this point, we're obviously awaiting the recommendations in terms of what the panel recommends based on best practices, so we'll look at the recommendations when we receive them.

Mr. Jeff Yurek: Okay. My next question is—and it just has to be a simple "I'm not telling you," or give me a date. I'm getting a lot of calls in my office that the

magical omnibus LHIN bill is coming to be introduced. Is it coming within the next week and a half?

Hon. Eric Hoskins: Certainly we look forward to introducing the LHSIA bill at the earliest opportunity. I can't give you a specific date at this point in time.

Mr. Jeff Yurek: Okay.

If you look on page 137, in every instance of a cut to the transfer payment to a LHIN in 2016-17 estimates, interim actual spending for 2015-16 was higher than the 2016 estimates. Can you explain the reasons for the difference there?

Hon. Eric Hoskins: Just give us a moment to find the reference. Page 137, was it?

Mr. Jeff Yurek: Yes.

Dr. Bob Bell: Sorry, Mr. Yurek. You're suggesting the change from 2015-16 estimates to 2016-17 estimates is negative?

Mr. Jeff Yurek: Yes.

Dr. Bob Bell: For example, Waterloo-Wellington is a $6-million increase; Central West, a $4-million increase; Toronto Central has a small negative of $108,000; Champlain $3 million incremental, for a total sum of $14 incremental from 2015-16 to 2016-17.

Mr. Jeff Yurek: Yes.

Hon. Eric Hoskins: As the deputy mentioned, overall, the change in estimates from the previous year represents an increase of roughly $14 million. In addition to that, it's anticipated that that number will increase because the home and community care investment that was referenced in the recent budget hasn't yet been added. Obviously a significant component of that will flow through the LHINs as well.

Mr. Jeff Yurek: On page 144, you have a $100-million investment in community services. Could you explain where the community services money is going?

Dr. Bob Bell: Sorry, say that again—144?

Mr. Jeff Yurek: On page 144, the third item, community services investment, you have $100 million roughly.

Dr. Bob Bell: Just let us check. I think I know the answer, but let me be certain on that. Minister, do you want me just to describe this? The total allocation has not been announced as of yet, Mr. Yurek, but if we use last year's allocation:

—$49.1 million to expand community service capacity, client acuity and reduce alternative level of care pressures in the hospitals;

—$5 million to support the implementation of proposed amendments under the Home Care and Community Care Services Act to increase the home care nursing availability;

—$1.5 million to support the indirect costs associated with delivery of community exercise and falls prevention;

—$6 million to support the continued operation of 250 convalescent care beds within long-term care;

—$3.8 million to offset reforms for funding within the CCAC systems; and, of course,

—a $77-million increase in PSW wages last year by $1.50. This year, there will be a similar increment of $1; and

—a base allocation of $20.9 million incremental related to the continuation and expansion of the health links program.

That was the total for last year of—just adding it quickly—a little less than $204 million, probably about $180 million. It's not totalled here, but doing the quick math, it was somewhere around $180 million last year; this year, an incremental further amount for home and community services.

0910

The Chair (Ms. Cheri DiNovo): Mr. Yurek, you have about two minutes left.

Mr. Jeff Yurek: Two minutes? Okay.

Page 158: There was a $100-million cut to community and priority services, and provincial programs and stewardships. Can you give a brief explanation of what happened at that part with the transfer payments?

Dr. Bob Bell: Mr. Yurek, the $122 million that you see as the major negative there related to transfers that occurred during the year to look at solving pressures in programs, such as the cardiac program, the cancer program and the transplant program. This was essentially an accounting adjustment for increases that were made in other programs.

Mr. Jeff Yurek: Sorry—Associate Minister, good morning. I didn't see you earlier so I just wanted to say good morning to you.

Hon. Dipika Damerla: Good morning.

Mr. Jeff Yurek: Have any LHINs clawed back any transfer payments to hospitals they've deemed as overpayments this past year?

Hon. Eric Hoskins: Not that we're aware of, no.

Mr. Jeff Yurek: How many LHINs have already begun to implement the Patients First discussion paper?

The Chair (Ms. Cheri DiNovo): I'm afraid that's the end of your time, Mr. Yurek. You'll have to sit with that question.

We now go to the third party. Madame Gélinas.

M^me^ France Gélinas: I am just going to ask a quick question about his line of questioning at the very beginning. We were all there—and I think you were there, Minister—when RNAO came for receptions downstairs and told us in no uncertain terms that if the government doesn't move with offloading devices for people with foot ulcers, mainly people suffering from diabetes, they intend to bring 2,000 amputees onto the front lawn of Queen's Park to drive the point home that if we don't do this, every single year in Ontario, 2,000 people lose a limb to foot ulcers.

In piggybacking on what he was asking, are we going to do something to avoid this demonstration of 2,000 amputees on the front lawn? I would rather those people don't have to come here.

Hon. Eric Hoskins: Certainly at the time of RNAO's Queen's Park day, we had already established a table through HQO to look at the issue of wound care for

diabetics, including the issue of offloading devices. They had been invited to participate, so they were aware that this table existed and their participation was essential.

As you can appreciate, it's important for us to bring together the best clinical experts and advocates on this issue to develop the appropriate clinical guidelines for their use and recommendations for the government. I've had a number of conversations, including with RNAO, Wound Care Canada and others, about this issue over the past while.

As I referenced earlier, we anticipate in the near future that we will have recommendations flowing from that table, which I think is the appropriate process to follow. Depending on the nature of those recommendations, we'll have the opportunity as a government to act.

M^me^ France Gélinas: If we look at time frame, is there a chance that the time frame for all this good work to happen will be done before this fall?

Hon. Eric Hoskins: We want to make sure that the table doesn't feel constrained in terms of arriving at their recommendations. It really is up to them to determine the amount of time they require to provide recommendations to the government. That being said, I anticipate that the timeline you suggested is probably a reasonable one.

M^me^ France Gélinas: Thank you so much.

Just two quick questions. The first one has to do with updating the paramedic training standard, more specifically for oxygen administration and spinal immobilization. Right now, paramedics are required to apply spinal immobilization as per the standards, even in events where best practices would tell you that it is not the best course of practice. You are quoted saying—actually, it's in a letter. You wrote that the emergency health services branch would be updating paramedic training standards and that it would be in early 2016. Early 2016 is coming to mid-2016. This is May 31, after all. I was just wondering, are you going to meet this timeline commitment that you had made in the letter or are we looking at a new timeline for updating paramedic training standards?

Hon. Eric Hoskins: I might ask the deputy to add to this.

I'm hoping that you'll grant me the ability to answer this in a more fulsome manner slightly later for the sole reason that the ministry official who's responsible for this file is currently in committee elsewhere.

Deputy, you may have a more fulsome answer, but I would appreciate having the value of her input. She would be able to provide, I think, the clarity that you're asking for.

M^me^ France Gélinas: No problem. I'll bring it back. Just flag it to me when that person is here.

Hon. Eric Hoskins: Thank you.

M^me^ France Gélinas: All right. I had asked a number of questions about long-term care and then, when I reviewed what I had asked, I had forgotten to ask the most important one. I guess I wasn't clear enough as to the average number of hours—to the associate minister—of hands-on care and how you do this calculation. I see that the researcher has written the question as outstanding, but, this particular one, I guess I was not clear enough when I asked. If I were to ask you right now, what is the average hours of hands-on care provided in our long-term-care homes, the answer would be?

Hon. Dipika Damerla: I think the answer would be the hours of care that somebody needs, because the principles on which we fund any home or any bed is really driven by the acuity of that resident. We really fundamentally believe that care has to be tailored to the needs of the resident, and so the correct answer to your question would be the number of hours that the person would require.

M^me^ France Gélinas: I fully agree with your answer, but I would say, because we're at estimates and we're following the money right now, if you look at the money that is being spent through our long-term-care lines in the budget and you look at the number of residents, what would that come out to, as to the number of hours of hands-on care?

Hon. Dipika Damerla: I think the last time you asked this question, I had responded, in terms of that exact number that you are looking for, that we would consider your question and see if we could get back to you. I believe that's a request you've already put in.

But I really don't want to miss the opportunity to underscore—and you probably understand this—the real importance of not getting caught up so much in average numbers as much as in what a resident needs, what is their acuity and what we can do to constantly refine our ability to fund a bed and a person in a manner that reflects their true needs.

M^me^ France Gélinas: I agree. It's just, as I said, when I reviewed the Hansard—I think you get it. But I guess I was not clear enough at the time, so I wanted to be clear that time.

Hon. Dipika Damerla: You're very clear.

M^me^ France Gélinas: All right.

Just one quick number: We all know that there are barriers to access for trans people. Important work has been done to build primary care capacity for trans people, but significant barriers continue to be there for publicly funded procedures for many trans Ontarians.

0920

In June of last year, I made the comment that there were 970 individuals on the wait-list. In November of this year, it has risen to 1,064. Every month, the list goes up, not down.

First of all, do we track what the wait-list is for, as in how many people are waiting for sex reassignment surgery? How long is the wait time for those people? Do we track it, and where are we at in the specific number of people waiting and the number of months or years that they have to wait?

Dr. Bob Bell: Since March 1, 2016, the ministry has approved over three times the number of requests for approval of insured sex reassignment surgery, compared to the same time last year—

M^me^ France Gélinas: So that's from five to 15?

Dr. Bob Bell: In 2015-16, there were 117 insured sex reassignment procedures. I'm not exactly sure of the rate within the first quarter, but certainly the rate of approval has increased pretty dramatically.

I'll also mention that what I'm referring to is the undertaking of insured services. The assessment, of course, is probably what you're referring to, the wait time for assessment. Many patients are assessed for each patient that actually has approval for undertaking a sex reassignment procedure.

The increased number of referrals is certainly being responded to by increasing funding. As you know, in the 2016-17 estimates, we're estimating $4.3 million for expenditures relating to sex reassignment surgery only, as compared to 2015-16, where the budget line was $2.99 million.

In addition to additional training for health care providers focusing on transgender issues and providing assessment for sex reassignment surgery—it used to be that the Centre for Addiction and Mental Health adult gender identity clinic was the only place where assessment and consultation regarding appropriateness for sex reassignment surgery was undertaken. We've expanded that now, of course, to many other health care providers who are trained in transgender issues. That training has been developed by Rainbow Health Ontario and is being applied much more broadly.

There's planning under way. As you know, currently, most sex reassignment surgery is done outside the province, in Quebec or, in rare instances, in an American centre, but there is planning under way for potentially repatriating aspects of SRS to an Ontario centre. We do have interest from one of our centres for undertaking that.

The number of procedures: We've gone from 29 procedures being undertaken in 2009-10 to 154 procedures in 2014-15 and 158 procedures in 2015-16. As mentioned, the rate of approval for SRS in the first quarter of this year has gone up by three times, compared to the rate of approval in the previous year.

M^me^ France Gélinas: All right. I will repeat my question. I thank you for sharing that with me, but the question is, how many people are presently on the list? How long have they been waiting for sex reassignment surgery?

Hon. Eric Hoskins: The list that you're referring to is which list?

M^me^ France Gélinas: People that have been assessed who are waiting for sex reassignment surgery.

Hon. Eric Hoskins: So they've been assessed and approved?

M^me^ France Gélinas: Assessed and approved, and waiting for sex reassignment surgery. We had 970 individuals waiting as of June of last year. In November of last year, it was 1,064, and every month the list is getting longer. How many individuals are waiting on the list for sex reassignment surgery at this point?

Hon. Eric Hoskins: The reason why I'm—

M^me^ France Gélinas: If you want to give me the list of the people waiting for assessment—

Hon. Eric Hoskins: No, the reason why I'm asking about the list is that I think you may be confusing two lists. The list of those who are waiting for assessment at CAMH, which is the figure in the 900s that you referenced, doesn't represent approval for sex reassignment surgery. Right? You understand?

M^me^ France Gélinas: I fully understand the two. My numbers tell me that there were 970 who had been assessed and approved, and who are waiting and waiting for years.

Hon. Eric Hoskins: I know the staff behind us are looking into that, but I would be surprised if that were the case. I think we may be talking about two different lists.

M^me^ France Gélinas: Then give me the numbers of people on both of those lists, and give me the wait time for both of those lists.

Hon. Eric Hoskins: Okay. And then, with regard to the first list, if I might—

M^me^ France Gélinas: Sure.

Hon. Eric Hoskins: Tell me to stop if it's not helpful. Due to the changes that we implemented, which came into effect in March, where virtually any trained provider across this province can provide that assessment and approval, along with the fact that we've provided additional clinicians and social workers at the CAMH site, that CAMH wait-list for assessment is much less important because of the ability of literally potentially hundreds of providers to provide that assessment and approval.

With regard to those who have been approved but are waiting for surgery, we will make every effort to see if we can help determine that figure.

M^me^ France Gélinas: Okay. And is any work on the way to have the sex reassignment assessment done in the north?

Hon. Eric Hoskins: Well, again, the beauty of the changes that we made is that it becomes provider-dependent. Providers who have the necessary training, in concordance with the WPATH recommendations, will be able to provide that assessment wherever they are.

M^me^ France Gélinas: But, Minister, this never serves the north well. When you make a policy, you have to put a lens of equity of access. If you let providers decide where they set up shop, it's fine for the providers, and it does improve access, but it does not bring equity, ever.

To bring equity, you have to be at the helm of your ministry and say, "Here's where those services are needed," not just "Where would you like to set up shop?" Because whether we're talking about PET scans or sex reassignment surgery—and I could line up many more services that are provider-dependent—providers do not come to northern Ontario, which means that the people I represent don't have equitable access.

We don't want the same as Toronto. We understand that we're never going to have double lung surgery done in Gogama; that's fine. But we want equity. When you put out a program like this but don't have any mechanism in place to make sure that we have equity, we don't.

Hon. Eric Hoskins: Well, first of all, I don't subscribe to the view that practitioners in the north, or other parts of the province, would be any less inclined or interested to provide this important service because of equity issues. Second, I would argue that going from a single site for assessment and approval to literally hundreds of sites across the province is a dramatic improvement in health equity.

M^me^ France Gélinas: It is. So I will get the number of people waiting at some point?

Hon. Eric Hoskins: I will do my best.

M^me^ France Gélinas: Sounds good.

The Chair (Ms. Cheri DiNovo): Madame Gélinas, you have about two and a half minutes.

M^me^ France Gélinas: Really? How long was the thing?

The Chair (Ms. Cheri DiNovo): Twenty minutes.

M^me^ France Gélinas: Really? All right. A short question, then—none of my questions are short.

Hon. Eric Hoskins: Tell me about it.

0930

M^me^ France Gélinas: Back to the Assistive Devices Program: Now that Shoppers has dropped off the ADP program, how do you make sure that there is equity throughout the province for access to meet your ADP commitment?

Hon. Eric Hoskins: If you'll just allow us a moment.

M^me^ France Gélinas: You have two minutes.

Dr. Bob Bell: We have 1,100 vendors that we're working with at the retail level to provide services across the province for the ADP program.

M^me^ France Gélinas: If you don't mind, I would like to have a geographical distribution of those 1,100 vendors, just to see how the different parts of Ontario are serviced.

Dr. Bob Bell: Okay.

M^me^ France Gélinas: Thank you. I'll save my 30 seconds.

The Chair (Ms. Cheri DiNovo): You've got about a minute and 30 seconds.

M^me^ France Gélinas: Do I? Okay. I have heard, more and more, that there are collusions between long-term-care homes and ADP suppliers. I was wondering if there have been any investigations done by your ministry or the department involved to look at collusion between long-term-care homes and ADP providers who do not benefit the public purse.

Hon. Dipika Damerla: Sorry, can you just clarify what ADP provider—

M^me^ France Gélinas: Sure. A long-term-care home procures all of their ADP equipment—you know how the system works. It's actually the patient who gets the wheelchair, etc. They always funnel it through the same ADP provider, although another ADP provider in the same city could have provided that patient with a much lower-cost wheelchair.

Dr. Bob Bell: We do have an investigation branch that evaluates that. It is an area that we've been looking into over the past year—

The Chair (Ms. Cheri DiNovo): I'm afraid we're going to have to leave it there and move to the government side at this point.

Ms. Indira Naidoo-Harris: My question is directed to Minister Damerla. Minister Damerla, recently there were some startling statistics that came out. Recently, Canada reached a new milestone. The numbers that came out are that essentially there are now more people over the age of 65 than there are children under the age of 14. This really represents a remarkable shift in our society, and it's an important demographic shift, especially when we're looking at not just our society but the impact that this could have on our health care system and the lasting impact it could have on our long-term-care system.

At the same time that this happened, there was also another number that came out, and that number had to do with median age. The new median age in Canada is now estimated at being 40.5 years. That's essentially the oldest it has ever been in the history of the country. It's absolutely clear: Society is changing and our population is aging. As you know and as we all know in this room, this could have serious effects on our health care system.

In January of 2015, Ontario's Patients First: Action Plan for Health Care was launched. It was launched with a vision to really transform health care and transform the way we deliver health care in our province. What we are now doing is putting patients' needs first. We're changing things around a bit. We're not so much concentrating on how we're delivering the services, but we're looking at the experience of the individual going through the system.

To meet this commitment and build on the action plan, the ministry has been establishing—to set a foundation, essentially, for a consistent and integrated approach to health system capacity planning. Of course, when we're talking about our seniors and the aging demographic, capacity planning is going to be key for us to be able to deliver quality health care to all Ontarians.

This is, of course, very important work. As our population ages and more and more Ontarians may need to rely on the care provided by one of our hospitals or the specialized treatment care facilities and long-term-care facilities, we all expect that our parents and our grandparents are going to get the care that they need. I can certainly tell you, from my own experience—my father is 85, almost 86, and he has just moved in with us. I'm very aware now of just what his care needs are, in terms of his aging, and health is at the centre of much of what is happening with him.

I've also been doing some work in terms of dementia and Alzheimer's and so, as a part of that work, I speak to seniors on a regular basis. Quality health care and preparing for people as they age, and creating an environment where they can get the care they need, is absolutely important, because, after all, these are the people who took care of our needs when we were younger. As a society and as a province, we want to ensure we're doing the same for them.

Minister, could you please provide this committee with an update on the plan to ensure that our health care

system is able to meet the demands of our parents and grandparents, both now and in the future?

Hon. Dipika Damerla: Thank you, MPP Indira Naidoo-Harris, for that excellent, excellent summary—

Ms. Indira Naidoo-Harris: Thank you.

Hon. Dipika Damerla: —of exactly what our challenges are, and giving me the opportunity to reassure this committee that we are fully aware of the challenges, and how we are responding to them.

I will be sharing my time with my ADM, Peter Kaftarian, who will speak at length and give some detailed examples of what we are doing.

I'd like to begin by saying that when we look at the aging of seniors, it's beyond long-term care. It is the continuum of care that we need to provide. The Ontario government's entire strategy around aging is really driven by an absolutely fantastic report that was commissioned by Dr. Samir Sinha, which all of us are very aware of. He's a very well known gerontologist. What's really remarkable about that report was that Dr. Sinha wrote that in consultation with Ontario seniors. There were three things that came out really strongly in that report, that Ontario seniors told the province and Dr. Sinha.

The first, of course, was that today's seniors are living longer and healthier than ever before. That's really important for us to remember. Sometimes we are so focused on those who are not well, as we should be. But the remarkable thing about modern science, and modern medicine, really, is not only how much longer most of us are living but how much healthier many of us are living. That is a really positive story in terms of, yes, we are aging as a society and, yes, there might be more pressures on health care, but it's also important to recognize that more and more of us are also living healthier lives and have great expectations of what I call the third act.

The second thing that that report and Ontario seniors told us was that they want to live in their own homes as long as they can. That was the second-most important thing that came out of that report. We have taken that advice of Ontario seniors to heart, that they want to live in their own homes for as long as possible.

You will see that in many of our programs, not just coming out through the Ministry of Health but, quite frankly, through many different ministries, whether it's supports or renovation tax credits that we had for seniors, or property tax rebates for seniors—and not looking at it just from the lens of what the Ministry of Health is doing, but if you look at all of government, whether it's the accessibility piece, as we move ever more towards more livable urban planning—the whole goal is how we can make it easier for people to live in their homes for as long as they can.

Within the Ministry of Health, the biggest push that you've seen to help that happen, and to help us achieve that, is the focus we have put on care in the community. Minister Hoskins can speak more to it, but we have consistently increased funding to ensure that people get the care they need in their own homes, no matter what you call it.

We've now announced our affordable housing strategy, which will also go a long way in addressing the needs of seniors and their ability to live in affordable assisted housing, which is, again, a really key component of letting people stay in their own homes for as long as they can.

0940

Then, finally, funnelling down further, obviously, is the piece we all recognize: There comes a time when you've tried everything, and it is time for somebody to perhaps live in a long-term-care home. I know that almost every single MPP on that side—I should say on all sides, frankly—has had some experience. I think you mentioned once that a loved one was in a long-term-care home as well. All of us have the lived experience of having a loved one in a long-term-care home, and we know that that service is critical and vital as well for the family and for the resident. So we have been doing a number of things within the space of long-term care, but I'd like to highlight a couple.

The first one—you've alluded to it—is capacity planning. Capacity planning is something that is fundamental to what the Ministry of Health has been doing. The idea is very simple: We want to know the ideal number of long-term-care beds we ought to have, not just now, but going into the future, because as you can imagine, there is a lead time: If I need X number of long-term-care beds in five years, the work may have to start now. That capacity planning is well under way, and I know that Peter will speak more to that.

The other piece that is critically tied to capacity planning is our redevelopment of 30,000 long-term-care beds across the province. This is really critical, as many of you who are familiar with long-term-care homes or have loved ones—in every long-term-care home, the one thing I'm convinced of is that front-line workers do the very best they can to provide excellent care, but I think that bricks and mortar matter. We have seen some of the new, modern long-term-care homes, and they're just fantastic.

In fact, I recently visited one in Thornhill. It's called Mon Sheong, and I would love to get my name in right now. It's just a fantastic facility. What we would really like is to see every facility in Ontario like Mon Sheong: wide, airy spaces, lots of light, broad hallways. All of the rooms are semi-private; they don't have a basic room. They charge the basic rate, but they're all either private or semi-private; excellent staff, excellent facilities. It was such a joy to be there—a positive, vibrant place.

Redevelopment is a really critical part of our commitment to ensuring that long-term-care homes deliver quality care. As you correctly said, MPP Naidoo-Harris, this is for the seniors of our province, who are not only our parents and grandparents, but who also built the province and on whose shoulders we live today.

With that preamble, I'm going to turn it over to Peter.

Dr. Bob Bell: Just on the way over, Minister, if I may—pardon my voice—pay tribute to MPP Naidoo-Harris for the terrific work she has been doing, contributing to the ministry's capacity planning process and

understanding how the increasing prevalence of dementia really challenges us, but at the same time, new treatment methods in the home and the community for patients with cognitive decline offer real opportunities. Thank you, MPP Naidoo-Harris, for your leadership in helping us get this work out to the communities, and also helping us build that strategy. Thank you very much.

Ms. Indira Naidoo-Harris: Thank you for all your help with the work we've been doing.

Hon. Dipika Damerla: I echo the deputy's compliments. Now, if I can turn that over to Peter. Take it away.

Mr. Peter Kaftarian: Thank you, Minister.

My name is Peter Kaftarian. I'm the executive director of the health capital division of the Ministry of Health and Long-Term Care. Before I talk about redevelopment, maybe I'll just give a little snapshot of what my portfolio is responsible for, to set a little context.

The team that I'm responsible for has two branches: the health capital investment branch and the long-term-care home renewal branch. The vision of our division is to help build quality facilities to support excellent health care for the people of Ontario.

We directly support significant investments, whether they're hospital projects, community health centre projects or long-term-care redevelopment. These programs all fall under my purview.

The dedicated staff on my team work very closely across the ministry with our colleagues to administer the investments, program design, and technical and financial oversight to support transformation of the ministry and the system.

Within the two branches I mentioned, the health capital investment branch is currently managing over 100 projects that we have across the province, and the long-term-care home renewal branch was set up to support the redevelopment program specifically, or the enhanced long-term-care home renewal strategy.

As we have heard, we have a growing seniors' population and increasingly complex needs. We're continuing to see increased levels of demands on the long-term-care system and the residents who are actually being admitted into long-term-care homes.

In order to address this challenge, we are looking at our current and future long-term-care resident populations and recognizing the important role that long-term-care homes have in providing quality care and service to residents with daily living and access to 24-hour nursing care and support in a residential setting. Of the approximately 78,000 long-term-care beds in 630 homes, there are close to 30,000 beds that are part of our redevelopment program. To renovate or rebuild these homes by 2025 is our target.

There have been a series of programs in the past that I'll just skip over and jump right into our more recent programs. One that has come up a few times in the committee is the Long-Term Care Home Renewal Strategy. It was announced in 2007. It was to redevelop 35,000 beds that were targeted as B, C or upgraded D beds. The program kicked off in 2009, and fewer beds than anticipated were taken into the program.

What we did to launch the enhanced strategy was to make changes: How do we get the operators in the sector—whether it's for-profit, not-for-profit or municipal—interested in the program to rebuild, in order to ensure that we have these homes up to the most current design standards?

In the fall of 2014, the Enhanced Long-Term Care Home Renewal Strategy was announced. This strategy will help long-term-care operators redevelop these homes. Residents will benefit from the redevelopment of these homes to make them as home-like as possible, because these are homes. These are not institutions or facilities; this is a residence home. That's an important thing to remember every time we go on tours: This is somewhere someone lives, as opposed to a facility or an institutional setting.

Since the announcement, we've made significant progress. I'll just talk a little bit about it. We announced it in the fall of 2014, and we immediately did a stakeholder consultation session. This lasted a couple of months, and there were approximately 40 different organizations represented in each of these sessions.

At the end of the stakeholder sessions, as part of that announcement, we did announce a project office in the fall of 2014. This is a dedicated office; all that these staff do is redevelopment. We've got a team, we've got a director lead, and their entire focus is developing and implementing the program, and making sure that program is successful.

There was an increase in the construction funding subsidy that I'll talk a little bit more about in detail after I get through a few more bullets, as well as supporting an increase to the preferred accommodation premium that operators are permitted to charge and extending the licensing term from 25 to 30 years. Now, if you redevelop a home and you receive a licence, you now have a 30-year operating window to run your home, as opposed to 25, which has been the most recent program.

We also set up a committee to review variances to design requests. We understand that, for example, in an urban setting in the city of Toronto, where you may be land-locked and you want to renovate your home, you may not be able to renovate to exactly what our design standards say because, for example, you have a support wall that you cannot move.

The historical program said, "If you can't build to these design standards, we're going to reduce the subsidy that the ministry will provide." We've set up a committee that will hear operators who come in and say, "Here's my situation. Here's why I can't build to exactly the number of square feet. I can build a private room that's two feet less than your minimum. This is the best that I can do. I can maintain quality of life and quality of care to the resident. I don't want to be deducted from the subsidy I'm providing. Can I have some consideration for not being penalized for this, due to my unique circumstances?" This was also part of our strategy, and we committed to roll that out.

Maybe I'll talk a little bit about the construction funding subsidy because it is one of the things that we

seem to spend a lot of time on, just understanding with the sector. The construction funding subsidy is a subsidy. We don't actually provide the funding for the full cost of redevelopment. It's a subsidy. Operators are expected to put some of their own equity into the process, whether it's land or otherwise.

Once a long-term-care home redevelops, we provide a per diem over the course of 25 years. It starts off with a base per diem, which is $16.65. Then there is also an addition to the home size: How big is your home? For these smaller homes in the north—we had, on one of our stakeholder committees, a municipal home from the north who explained that they don't have a lot of clientele who want to pay for private accommodation. Their main clientele want a basic room. They don't mind sharing, or they can't afford the cost for a private room.

We actually provide an additional subsidy for these smaller homes, up to $1.50—these would be homes under 96 beds—on top of that $16.65. A medium-sized home, which is 97 to 160 beds, gets an additional 75 cents. A large home is over 161 beds.

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What's important to note on this is that we worked with the sector to come up with these ranges. We had an envelope to work within, but we worked with the sector on what's deemed to be a small home, what's appropriate as a medium home or a large home, and that's how we've delineated it.

From an environmental perspective, we do provide a dollar premium if the home builds to LEED silver—

The Chair (Ms. Cheri DiNovo): Assistant Deputy Minister, you have two minutes left.

Mr. Peter Kaftarian: Okay, thank you.

We also have basic accommodations. Building on what I mentioned about homes in the north, if you build up to 60% of your home as a basic accommodation room, you'll receive an additional $3.50. We also have an enhanced transition support, so if you're renovating your home, we do provide a premium to support. For example, if you're renovating part of your home and the remaining part of your home is open, and you've got additional cleaning requirements in order to maintain your home-like setting, we do have this additional amount to support the home. Not-for-profit homes also receive a grant of $250,000 to support the early planning.

That's the construction funding subsidy in a nutshell. We made significant changes to that policy based on sector feedback and rolled it out as part of our program in 2014.

The ministry is also currently in the process of piloting a new process aligning approvals and licensing. One of the challenges in the past has been, when does the formal licensing process happen compared to when does the formal approval process for your home occur? We've been working very closely with the long-term-care home division and we're now trying our best to align these processes. So when you have approval to redevelop, you've also got approval of your licensing. The licensing is a legislative process, and we're trying our best to align these two to create more efficiencies and speed up the process for redevelopment.

I mentioned stakeholder consultation, and that's been an absolutely critical reason for the success of our early engagement. We have a stakeholder committee with representation from associations—from AMO, from for-profit, not-for-profit, municipal. We have a resident on our committee; we have a family from the residents' council, family council. We meet every two months. We were meeting monthly at the start and we've spaced it out a little bit.

This engagement with the sector has been critical for us to understand what some of the issues are with the program, how we can fix it and how we can make it more effective.

The Chair (Ms. Cheri DiNovo): Thank you, Deputy Minister. Now we go to the official opposition: Mr. Yurek for 20 minutes.

Mr. Jeff Yurek: I guess I'll just go back to where I left off with the Patients First discussion paper. How many LHINs have started to implement some of the elements of that paper?

Hon. Eric Hoskins: None.

Mr. Jeff Yurek: Okay. My LHIN, South West LHIN, has already created its sub-LHIN structure. Can you maybe verify that answer?

Hon. Eric Hoskins: Long before the discussion paper, but certainly subsequent to it, we've had in-depth discussions with a variety of stakeholders, including our LHINs, obviously, in preparation for eventual legislation and the transformation that's outlined in the discussion paper. That was further refined as a result of consultations since December. There have been preparations and refinements made.

As outlined in the discussion paper, if the intent of the government is to proceed with, for example, sub-LHIN regions, then it's responsible, I think you would agree, for the LHINs, together with the ministry, to begin the process of looking at what the delineations, the demarcations or the boundaries of those sub-LHIN regions might be.

Dr. Bob Bell: If I may just add one comment on that: One of the major functions of the LHINs is to integrate care for complex patients. One of the most important initiatives that they've introduced is the concept of health links. It really looks, especially at the South West LHIN, as if the current geography for health links actually may fit very well with the eventual development of sub-LHIN geographic areas. That's the kind of organization of services that's been undertaken in South West to parallel the health links process, and looking to potential organization of primary care as well.

Mr. Jeff Yurek: So you've given direction to start preparing for this change that's coming?

Hon. Eric Hoskins: I guess how I try to characterize it is that obviously it's subject to legislation being introduced and passed. If passed, we would then enter into an implementation stage. We benefited from the good advice of our LHINs, among others, even prior to the dis-

cussion paper but subsequent as well. We continue to refine the model that we're proposing and make preparations, I would call it in a theoretical sense, to do the due diligence to have the confidence that the model we're proposing is an effective one, that we have been working with our LHINs on those issues. To refine the proposal, to look at potential models, to look at if we ultimately, through approved legislation, go down the pathway of sub-LHIN regions, we've asked our LHINs working with us and with other stakeholders to ascertain what those demarcations might look like.

Mr. Jeff Yurek: Since they've started to create the sub-LHIN structure, have you received any reports outlining the costs that may be associated with these new sub-LHINs and how they will function? Do you have any projections you could share with the committee?

Hon. Eric Hoskins: It's always been important to myself, the government and the ministry that we not create another layer of bureaucracy or another structure. I think the deputy was entirely right and appropriate in referencing health links. That provides a model, I think, including demarcation of boundaries that are, generally speaking, aligned with perhaps municipal boundaries or the places where people live and work and play and otherwise.

What we're talking about is the ability to really provide an even more local response to the health care needs and priorities of communities based on the ability to—particularly in large LHINs, like in the north. I had a good discussion with the mayor of Kenora yesterday about the challenges that he faces in a LHIN as vast as it is, so the idea is to be able to drill down and refine an approach so it's more responsive to local needs but to utilize the existing health care leadership, including potentially through the health links structure, to be able to provide that local leadership and refinement of services to do the capacity planning to identify what services are being provided and what the health needs of the population are, and then to respond accordingly.

Mr. Jeff Yurek: So you don't have any cost analysis done on how these are going to function or affect the system?

Hon. Eric Hoskins: We've looked through the entire model that we're proposing. Of course, we've looked at the fact that we expect—as with the CCACs being dissolved, or at least that's the proposal that would be put forward, presumably—as those services migrate to the LHINs and further through the LHINs to the front line, we anticipate significant savings will be found both at the management and administrative level, but also through other organizational change. That will allow us to reinvest funds in front-line services, services that will benefit patients directly. So we have—

Mr. Jeff Yurek: How many positions are you planning on eliminating?

Hon. Eric Hoskins: Again, we're still going through the process. We haven't yet, as you know, introduced legislation, so this is in the planning phase. We haven't yet ascertained the precise number.

Our objective in the first instance—well, we have several—would be to ensure that that transition, in the case of the CCAC activities, the home care activities, as was accomplished a number of years ago when we reduced the number of CCACs from in the 40s to 14, has the objective that no home care visits will be lost, that the impact on the patient with that transition will be unnoticed. With that as the objective, in the first instance, of transitioning the care under the authority of the LHINs, there are a number of steps that will be taken. Through those steps, we will be able to ascertain what reduction in FTEs, or perhaps transition of FTEs to another area of care, might actually take place.

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Mr. Jeff Yurek: So you have a structure that you've theoretically planned out, you're saying you're going to create these savings to go to front-line care, but you can't tell me how many positions we lost to create those savings to get it to front-line care? Unless you're going to infuse it with a whole bunch of new money into the system.

Hon. Eric Hoskins: Well, as you know, we are infusing a whole bunch of new money into the system: $250 million a year into home and community care. But I would hope you can appreciate that, when legislation hasn't yet been introduced, your request to have a specific number of individuals that FTEs may be reduced by, a specific number—I think that perhaps might be a question best asked at a slightly later point in the implementation process.

Mr. Jeff Yurek: How about a ballpark figure of how much money will be saved from FTEs in total? Instead of a number, give me a total.

Hon. Eric Hoskins: Well, look, I think there's a reasonable expectation by the public that we continue to augment the resources that are invested in front-line care that truly benefits patients. That's the intent, in part, of transitioning CCAC activities into the LHINs, and that's apart from a number of other efforts being made to create a more uniform approach in terms of the consistency of care and the expectation of care that one can receive across the province.

So we have, for many, many months now, been working on this model and we continue to refine it, but I think that given that the legislation hasn't yet been introduced, I am reluctant to speak categorically in terms of what the specific elements might look like.

Mr. Jeff Yurek: Legislation hasn't been introduced, but you've already started creating the sub-LHIN structure—

Hon. Eric Hoskins: No, we have not. No.

Mr. Jeff Yurek: Okay. The South West LHIN has told me that they've created the sub-LHIN structure, so—

Hon. Eric Hoskins: Well, they may have proposed to the ministry for their specific LHIN, if we were to move forward with a model that resulted in sub-LHIN regions, what those sub-LHIN regions might look like.

Mr. Jeff Yurek: Okay. So the $250 million that you said would be infused into the system is for the current

system as it's running now. Do you see changes in how that money has been allocated into the budgets with regard to the new structure that you're creating?

Hon. Eric Hoskins: Bob, do you want to speak to that?

Dr. Bob Bell: Yes. I think probably the opportunity for improving efficiency in home care—ahem.

Hon. Eric Hoskins: I shouldn't have thrown that at you.

Dr. Bob Bell: It'll come. Don't worry. It's getting better all the time. Ahem. There, it's back.

We expect that the opportunity to actually improve both the efficiency and quality of home care will really come out of the 10-point plan that was introduced last year following the expert panel chaired by Gail Donner. Issues related to standardization of home care through introduction of levels of care; describing patient needs and lining attribution of services; along with standardization of contracts, self-directed care and post-discharge bundled care: These are all elements that have increased efficiency of home care provision, increased the hours of home care available to clients and, most importantly, standardized processes for home care.

The continuation of the 10-point road map for improvement of home and community services is really an essential counter or a partner piece to the potential changes that could roll out with LHIN renewal.

Mr. Jeff Yurek: Chair, how many minutes do I have?

The Chair (Ms. Cheri DiNovo): You have about eight minutes.

Mr. Jeff Yurek: Good. Just to sidestep the LHINs, if you look at your budget this past January—I haven't been able to find an answer for this; maybe you can shed some light. In table 3.26 in the budget, there are notes that revenue from the Ontario lottery to the operations of hospitals has decreased by $107 million. Can you explain, first of all, where that money goes in the system for the operation of hospitals, why the cuts and how that is going to affect the system?

Interjection.

Hon. Eric Hoskins: The deputy is informing me that we don't have the relevant chart available to be able to provide advice on that matter. Is that correct?

Dr. Bob Bell: That's correct, Minister. Our apologies.

Mr. Jeff Yurek: The chart from the budget?

Hon. Eric Hoskins: Yes.

Mr. Jeff Yurek: Do you want a copy of it?

Dr. Bob Bell: We will come back with it, for sure. I just don't think we have a copy of that chart here.

Mr. Jeff Yurek: Okay. I was going to give you eight minutes to answer that, too. While I wait for that answer, let's talk about the Welland hospital. The MPP from Welland submitted a petition about the closing of the hospital in Welland with close to 23,000 signatures. The Ontario Health Coalition has also held numerous referendums about the closing of hospitals in Welland and Port Colborne.

How much more can these people do to show the government that they want these hospitals to remain open, and what can be done to ensure that they have proper access to service? What I'm hearing from these people is that to reach a hospital that will be available to them is far off or an emergency ride in an ambulance.

Hon. Eric Hoskins: As you know and can appreciate, my objective throughout the province, including the Niagara region, is to ensure that local residents and the population have good access to high-quality health care. The proposal that has been developed, the recommendations and the proposal that flowed from it, which was the result of the work done by Kevin Smith and others in Niagara recommending the siting of a new hospital—they have received a planning grant to assist them and the community in that process. I'm actually impressed and struck by the breadth of individuals, including representing the areas you've referenced, and the talent that are part of that consultative process and part of the committee that is advising the hospital as they look at next steps.

Recently, in March, the Niagara Health System released their proposed future plans, including the Welland site, as you know. Their plan, which has not been approved—it's simply a proposed plan from the Niagara Health System at this point—actually involves and includes the building of two new stand-alone buildings at the current Welland hospital location that would, in a combined sense, represent about two thirds of the existing space, and there would be a wide variety of services, including urgent care, long-term care and ambulatory care, that would be provided at that site. This is a proposal that the health system has put forward, which the ministry and the LHIN are currently looking at.

In the meantime, I've had a number of conversations with community members, including the political leadership as well, representing Welland and other regions affected by these proposed changes. I'm open, as I was during those conversations, to hearing from them in terms of what their needs are and their proposals to ensure the delivery and accessibility of high-quality care. I would summarize the proposals that are being put forward as being the result of extensive consultation that has taken place over a number of years, fully and wholly focused on the delivery of quality services in an accessible fashion, and then further refined and benefiting from a wide variety of individuals, experts and community members from throughout the region who I believe are able to effectively represent the needs of the disparate various groups within the region itself that would benefit from the changes being proposed.

That being said, I remain fully open to, and have engaged in a number of, conversations with those who represent some of the areas that would come under the umbrella of the services, to hear from them about any concerns, as well as proposals for ensuring that they will have confidence in the outcome.

Mr. Jeff Yurek: Any word back on the lottery funds yet, or am I going to have to wait till this afternoon?

Dr. Bob Bell: I think so, yes.

Mr. Jeff Yurek: This afternoon? Okay.

The Chair (Ms. Cheri DiNovo): Dr. Bell, if you could just be a little closer to the microphone when you speak? Thank you.

Dr. Bob Bell: Sorry about that.

The Chair (Ms. Cheri DiNovo): And Mr. Yurek, you have about two minutes left.

Mr. Jeff Yurek: Two minutes? Okay.

You committed $10 million in the budget with regard to long-term care. How much of the $44 million in annual base funding for Behavioural Supports Ontario is allocated to help the long-term-care residents in general?

Hon. Dipika Damerla: One of the things that we are really, really pleased with in that budget—thank you for asking the question—is the fact that we're increasing the budget for Behavioural Supports Ontario, because it's a critical piece, and a recognition by us that, indeed, the acuity in our long-term-care homes is going up and the fact that aggressive behaviours are prevalent in long-term-care homes. That's the reason we're investing in BSO. We've increased funding for BSO by $10 million.

One of the things in health care that I think we are really, really trying to do is to move away from the silos of long-term care and community care, and really move to the continuum of care. That's really important. So BSO, as it is structured now, the bulk of the $45 million does get spent in long-term care, but a portion of it also does go to support people who may be in the community, either transitioning into—

Mr. Jeff Yurek: So what's the breakdown? That was the question.

Hon. Dipika Damerla: The breakdown—I think we can get you the numbers, but I'm quite comfortable saying that the vast majority of the money, whether it's the $45 million or the proposed $10 million—

Mr. Jeff Yurek: When will I get the numbers? This is estimates. It's all about numbers.

Hon. Dipika Damerla: Yes. You're not letting me finish my thought, though, which is the idea, the principle, that the bulk of the money will be going into long-term-care homes. I'm going to say—

Mr. Jeff Yurek: When will I get the numbers? That's the question now.

Hon. Dipika Damerla: I'm going to say that the split is somewhere around 80-20 or 70-30, but we will endeavour to get you numbers on that.

Mr. Jeff Yurek: You will get me the numbers?

Hon. Dipika Damerla: Endeavour to get.

The Chair (Ms. Cheri DiNovo): I am afraid that that is all the time we have. We are going to recess now until 3:45. Thank you, everyone.

The committee recessed from 1013 to 1554.

The Chair (Ms. Cheri DiNovo): Good afternoon. 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 10 hours and 32 minutes remaining.

When the committee recessed this morning, the third party was about to begin their 20-minute round of questions. Madame Gélinas not being here, we're going to move to the government side, and you have 20 minutes. Ms. Indira Naidoo-Harris.

Ms. Indira Naidoo-Harris: Thank you, Chair. Good afternoon, Minister. My question is actually for Minister Eric Hoskins. My comments today are going to focus on dementia.

As you know, I have been working on a dementia strategy for some time, and most of us in this room, I think, have been affected either directly or indirectly at some point in our lives by Alzheimer's and other dementias. I know it's never easy, and I know first-hand how devastating these diseases can be. You see, a little while back my father-in-law Tommy was diagnosed with dementia. It was a hard thing for my family to watch as this disease profoundly changed him. So this topic is very personal for me.

The reality is that there are tens of millions of people around the world who are just like Tommy and will eventually forget the names of their friends and family. Closer to home here, it's estimated that over 200,000 Ontarians are currently living with dementia and, as our population ages, that number is going to rise to close to 400,000 by 2038. While dementia is most common among seniors, it's important to note that one in every thousand persons under the age of 65 develops dementia.

The social, economic and personal impacts of dementia are substantial. In fact, between the years 2008 and 2038, it's estimated that dementia is going to cost Ontarians close to $325 billion in direct health costs, indirect costs and opportunity costs for care partners. There can also, of course, be considerable personal financial burden for people living with dementia. It's estimated, in fact, that the average out-of-pocket cost for people with dementia is close to $1,000 per day.

These numbers, as you know, as compelling as they are, don't tell the whole story. Numbers don't speak to the toll that the disease takes on individuals and their families, and they don't speak about the incredible heartache this disease causes. But it is possible for people with dementia and their care partners to remain healthy and to live well, if the right care and supports are available to meet their medical and social needs, and that's the challenge we're facing today.

As you know, Minister, I am now working on a strategy—a strategy to care for people living with dementia and Alzheimer's disease. Our team has been working tirelessly for some time to accomplish this task. I recently ended some round tables across the province, close to eight of them, to hear from Ontarians about best practices, challenges and opportunities in dementia care. We heard from people in Mississauga, in Milton, in Ottawa, in Brantford, London, Toronto, Sudbury and Thunder Bay, just to name a few. I also toured medical facilities, research facilities, met one on one with dementia patients and experts, and attended numerous events and conferences related to dementia and Alzheimer's. We met with experts in the field, front-line health care partners, people living with dementia and their care partners.

We did this because we were trying to find out where the gaps are, where the supports are and how we can

improve things. Our conversations were extensive, knowledgeable, insightful, full of expertise and, at times, very passionate. It was at times humbling to hear people's personal and often heartbreaking stories about living and coping with dementia. It was also uplifting to meet the people who worked tirelessly in our province to help their friends, their neighbours, their loved ones living with dementia to live well. Every one of those stories, conversations and consultations has helped to build our strategy to this point.

We now have a draft strategy, or a white paper, as you are aware. As we push forward, I have a vision as to how this plan will serve the people of Ontario. It's a plan that will ensure that all Ontarians with dementia and Alzheimer's disease, along with their families and care partners, are treated with respect, have access to information that allows them to make the best choices and are living well with dementia, helped by appropriate supports and services, where and when they need it.

It's a plan that will raise awareness to reduce stigma and that will educate people living with dementia and their care partners. It's a plan that will focus on accessibility, on cultural sensitivity and equity of care across the system. It's also a plan that will engage the full spectrum of services and sectors to make it easier to deliver comprehensive and coordinated care for people with dementia. We're going to ensure that there is appropriate system capacity across the full continuum of care. We're going to achieve this goal through evidence-based long-term planning, policy, infrastructure and investment decisions.

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Last, but certainly not least, we're going to ensure that our system is accountable and sustainable, because this is a plan that we don't want to just live for this year or the next year and just be a snapshot of what we need today. We really want it to be a living document that will serve the needs of Ontarians and those living with dementia, and their care partners, for years to come. We'll do this through, of course, ongoing evaluation and quality of our services and achievements. As I'm sure you can tell, and you know, this plan is important to me and to our team.

I'm happy to report that we have made great progress in the development of the strategy, and I'm excited about the good work that's being done across our great province to help people living with dementia—and also across the country.

I heard loud and clear that we have a lot more work to do, and I know that we can and we will make a significant difference in the lives of people with dementia, and their care partners. Together, we will make sure Ontarians have the supports they need to live well with dementia. I know this is a commitment from you too.

Minister, I know that developing a comprehensive, forward-looking dementia strategy is important to this government. What more can you tell us about the importance of this strategy and what the government is already doing to support people living with dementia, and those who care for them?

Hon. Eric Hoskins: Thank you to the member from Halton for the question but particularly for prefacing the question with her own personal experience. What I believe is so vitally important to the province right now is your leadership on this issue. I know that Ontario and Ontarians are in good hands when it comes to the development of a dementia strategy for this province because of the tremendous leadership that you've demonstrated, the consultations that you've undertaken and the feedback that I've received. You and I have remained close on this issue. I've been briefed, obviously, on the development of the strategy as it has been developing. I'm very proud of the fact that you have worked so hard and so diligently to ensure that you reached as many Ontarians as possible, to hear from them and, importantly, to hear from those who themselves have a form of dementia—perhaps Alzheimer's—and to hear from caregivers as well. It's those stories, and the advice that we can glean as a government from those closest to this important issue—it's that advice which really, I think, more than anything else, helps guide us in the direction where we need to go in developing a strong, robust and meaningful strategy to address this issue. So I want to thank you for that. As you say, developing a dementia strategy for this government and for this province is a very high priority of this government.

I'd like to ask my assistant deputy minister Patrick Dicerni, who is to my left, who is also well suited and knowledgeable about the issue of dementia from a departmental perspective—I'd like to invite him, in the minutes remaining, to better inform the committee on what our government is doing to support those living with dementia.

Patrick?

The Chair (Ms. Cheri DiNovo): Would you state your name, please? Thank you.

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

Thank you, Minister, and thank you, Parliamentary Assistant Indira Naidoo-Harris.

I want to supplement the minister's answer and structure my answer into three buckets, where we'll touch on some of the statistics, costs or known burdens to the system that you touched on in your opening, some of the current investments that are contributing to making life easier for those living with dementia, and articulate some of the path forward that you both touched on.

At the Ministry of Health, we're certainly committed to developing a strategy that addresses the needs for Ontarians living with dementia, and especially also those who care for them. We know that the World Health Organization tells us that dementia is one of the leading causes of dependency and disability amongst older adults.

People living with dementia typically have two or more chronic health conditions when compared to seniors without the disease. People living with dementia are

twice as likely to be hospitalized or visit emergency departments for avoidable conditions. They're likely to remain in hospital for longer than necessary while waiting for more suitable care settings to become available, have more prescriptions and need to see doctors more regularly and more often.

For families and friends, caring for someone with dementia can have a significant effect on their personal finances, as well as physical and mental health. As the disease progresses and the demands on the care partners increase, evidence is showing that people caring for someone with dementia provide up to 75% more care hours than other care partners, and one in five care partners reports feeling distress, anger, inability to continue to provide care or continue on with their day-to-day responsibilities.

Care partners may also have their own health problems to deal with, with one quarter of that group living with two or more chronic health conditions themselves that are often aggravated by the demands of their caregiving responsibilities, from a stress and work management perspective.

I've articulated some of those serious challenges and burdens that we all know. But there is a plan to address this, some of which has already been acted on and some of which is evolving—that you are well familiar with. As a big component of the ministry's Patients First strategy, that places persons directly at the centre of care and provides a framework for improving the health care experience and health outcomes for all Ontarians.

An important part of that Patients First strategy is improving access to dementia supports. Many of the initiatives currently under way strengthen that person-centred health care and support for people to live independently. For example, steps are being taken to improve how care is delivered in the home and community sector. This includes ensuring greater consistency in care, a better understanding of the services available and providing more supports for care partners.

In addition, the ministry has proposed changes, which we heard about a little in this morning's session, to expand the mandate of local health integration networks so they're accountable for the planning and performance of primary care and the delivery of home care services within their local areas. These proposed changes aim to create a health system that works efficiently to support patients, including people living with dementia and their care partners.

The ministry has also made some substantial investments over the last couple of years to improve the lives of folks living with dementia. This includes funding for various Alzheimer's societies delivering a range of services to improve treatment; a $10-million and a $10.06-million investment, respectively in 2013 and 2014, to long-term-care homes. These investments were focused on improving resident safety, preventing abuse and neglect, and advancing quality of care for residents with responsive behaviours or other specialized care needs.

Beginning in 2016-17, the province will continue to improve the long-term-care home sector by focusing on resident-centred care, responsiveness to responsive behaviours and also looking at ethnocultural needs. To support this, the government will increase its investment in resident care needs by 2% a year over the next three years.

The ministry is providing local health integration networks with annual funding of approximately $44 million to sustain Behavioural Supports Ontario, which we also touched on a little bit this morning, and staffing capacity to meet the needs of individuals with challenging and complex behaviours, wherever they may be living.

Also beginning in 2016-17, the government is going to be investing an additional $10 million for additional initiatives to help residents with dementia and other complex behavioural or neurological conditions.

Back in 2013, the Ministry of Health and Long-Term Care, along with the Ministry of Research and Innovation, partnered with the Ontario Brain Institute with up to $100 million, or $20 million per year over five years, to sustain and expand the institute's coordination and commercialization support for neurological research.

The Ontario government also supports a program called Finding Your Way. Launched in 2013, this is a partnership with the Alzheimer Society of Ontario. As part of Ontario's Action Plan for Seniors, Finding Your Way is a multicultural program that provides practical advice for people living with dementia to help reduce the risk of going missing, while supporting quick and safe returns should a wandering incident occur.

Just this past March, the minister responsible for seniors' affairs, Mario Sergio, reaffirmed the government's commitment by announcing an additional approximately $750,000 to help improve training and reach more people who come into contact with persons affected by dementia.

This is a sense of some of the investments or supports the government has already moved forward with, but the ministry is also working to make some improvements in the coming year. It has been a pleasure working directly with you and with my team. That's why the round tables that you hosted—in addition to those, the ministry set up our advisory panel group and the five working groups to provide advice on the development of our dementia strategy. The advisory group and working groups were composed of experts from across disciplines and included people living with dementia and care partners. The five working groups were structured to follow a person's journey through the early stages to the advanced stages of dementia, along with a group that addresses specifically education, prevention, and research and innovation that underpin much of the work that we're doing, going forward.

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In addition to the advisory group and working groups, we've also established a health director working group. That's an interministerial effort across the many minis-

tries that touch on this population. This ensures, in our view, that the strategy is not being developed in isolation to other important and related initiatives and that a whole-of-government approach is being taken to address the needs that span multiple sectors.

The feedback, input and advice received from round tables and the various working groups are being used to inform the development of the discussion paper that you touched on. As you may know, we had the ability to shop that discussion paper to some of our experts on our working groups and have received very positive feedback, not only from the experts but from some of the folks who have been living with the disease or are providing caregiver supports. They see the draft recommendations as making a tangible and immediate impact to the journey through the disease.

The paper is going to inform the foundation of our public engagement that we hope to be ramping up this spring and in the summer. The public engagement approach will ensure that wide ranges of perspectives are heard, over and above the 200 to 250 voices that we've heard through the round tables that you led. Taking that involvement to a broader group of Ontarians will help augment what we are already contemplating through that strategy.

It aligns with Open Government goals to increase public engagement, engage directly with Ontarians and make sure that decision-makers are hearing directly from the public. By reaching out to Ontarians, we hope to help shape our policies, programs and services and, at the end of the day, affect the lives of people living with dementia in a positive way.

We're going to create a comprehensive and forward-looking dementia strategy. That is the priority of our ministry and certainly what we've been challenged to do by the deputy, the minister and yourself. We look forward to moving forward with strategy development and continuing to work together to develop effective approaches to empower people living with dementia and their care partners to ensure that they're living meaningfully, living well and able to continue to participate in their communities.

Ms. Indira Naidoo-Harris: Thank you.

Chair, how much time do I have left?

The Chair (Ms. Cheri DiNovo): You've got two minutes.

Ms. Indira Naidoo-Harris: Just a further question, then: I'm wondering if you can tell me a little bit more about Behavioural Supports Ontario, the BSO; $10 million was moved forward on that recently. Much of that, I think, will also assist when it comes to patients with dementia. Can you expand on that a little bit?

Mr. Patrick Dicerni: Absolutely, I could. I would not want to speak for my ADM colleagues who are more directly responsible for the BSO program, but as we heard a little bit this morning, this is a program that not only provides supports to those living in our long-term-care homes but beyond the long-term-care home environment and the all-important training of staff within long-term care so that they can be equipped to better deal with some of the responsive behaviours that we see from residents with dementia who are living with the disease.

Some of the feedback that we've heard, not only through our dementia consultations but through the long-term-care homes operators' association, as well as direct feedback from members of the public, was on the impact and importance of that investment in terms of training staff in an appropriate way to de-escalate situations and, when situations are at a point of any responsive behaviour or violence occurring, that the staff—not only those who are interacting directly with the patient but a team of staff around the patient—know how to de-escalate that situation.

Ms. Indira Naidoo-Harris: Much of what I heard when I was talking to stakeholders who are out there and people living with dementia and their care partners—many of the conversations surrounded people who were care partners and the stresses and strains of looking after a loved one who could be challenging at times, and the demands that were placed on these care partners. I understand that—

The Chair (Ms. Cheri DiNovo): I'm afraid your time is up at this point. Thank you very much. As practice has it—we've checked with the Clerks—we will now go back to Madame Gélinas for her 20 minutes.

M^me^ France Gélinas: Thank you for using your time wisely. My first question is—I just wanted to finish on trans people's health, just to make sure. Do we keep track of the time as to how long it takes somebody who wants to be assessed now that we have many, many different assessment points?

Hon. Eric Hoskins: Certainly we do, in the context of the CAMH facility. We do that primarily through the wait times, and CAMH has, in the past, reflected what those wait times would translate into with regard to a period of time. But as I mentioned this morning, moving from a single site to potentially hundreds of sites—the ability for an individual to be assessed and, if appropriate, referred for SRS, for surgery, has really transformed the approach.

You had asked as well a question about equity in the north, and I do have some information that I could share with you if you'd like me to. Yes?

M^me^ France Gélinas: Go ahead. Thank you.

Hon. Eric Hoskins: There are hubs across the north, including in Sudbury and Sault Ste. Marie. For example, NorWest Community Health Centres are offering referrals and working to build surgical capacity. There are individual providers as well, like Dr. Sylvain Leduc, who are offering referrals, and there are also trained providers at CSC du Grand Sudbury and at Shkagamik-Kwe—I'm not sure if I—

M^me^ France Gélinas: Shkagamik-Kwe.

Hon. Eric Hoskins: Shkagamik-Kwe.

M^me^ France Gélinas: You were close.

Hon. Eric Hoskins: Thank you. At least I did it half-justice, perhaps. Rainbow Health, who is the lead agency with regard to training health care professionals, are

continuing to work on increasing capacity. They were on Manitoulin Island, for example, as recently as last week. Rainbow Health services are province-wide, and Rainbow Health is confident that, in their words, "There is full coverage."

We also have Dr. Blair Voyvodic, based in Renfrew county, who services the entire north, supporting patients who can't get to a network hub or centre. He sees patients through OTN. Because, as I referenced earlier, of the changes that came into place in March, expansion of services is not limited to the services provided by Rainbow Health themselves. Now any qualified provider in the province, including the north, as I've referenced some examples, can issue referrals to the ministry, and not just through CAMH. It's now provider-centric rather than site-specific.

M^me^ France Gélinas: That's very good. Where is a comprehensive list available? If you're trans people and you live in Gogama, how would you find out where the closest is? Do you guys keep track as to where those services are accessible or available, and if you don't, who does? They would connect with Rainbow Health?

Hon. Eric Hoskins: Certainly they could connect with Rainbow Health. They can also connect directly with the ministry. I believe we do possess—

Interjection.

Hon. Eric Hoskins: Through the health services branch, they would be able to—if they required, for example, that sort of information with regard to eligible or trained providers and their locale, that information could be provided either through ourselves or through Rainbow Health, which does the training itself, so they obviously would have a comprehensive list of those who have undergone the training.

M^me^ France Gélinas: Can I have this comprehensive list shared with me as of today?

Interjection.

Hon. Eric Hoskins: Yes. The deputy has just said that they'd be happy to look into it.

M^me^ France Gélinas: Okay. Thank you. That's finished on the trans.

As I was finishing, I was talking about the Assistive Devices Program. Deputy, you were about to answer my question when our very capable Chair informed us that the time was over, so I will repeat the question. Basically, you told me that there has been an investigation done by a department, which I'm not sure of the name of, within your ministry that looked at collusion between seniors' residences—and that could be a long-term-care home or a retirement home—and ADP suppliers.

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Dr. Bob Bell: Do you want me to start, Minister?

Hon. Dipika Damerla: Yes, please.

Dr. Bob Bell: Great. The verification and testing unit, ADP vendor review process, is what you're referring to, I think.

Post-payment reviews of ADP vendors are carried out by the verification and testing unit, which is a business unit of the accounting policy and financial reporting branch in the corporate services division.

The Assistive Devices Program and the verification and testing unit review vendors based on program data analysis, trends, client confirmation, letters and complaints. The role of the VTU is to plan and execute reviews of claims paid to ADP vendors and clients; to work with ADP to ensure due compliance with ADP's policies and procedures; and to identify inappropriate billings and potential abuse or fraud.

In this function, VTU's staff, in conjunction with ADP, drafts schedules of reviews to be undertaken during a fiscal year and reviews the plan with ADP. Reviews typically include contacting a random sample of clients across all the device categories over a rolling period; targeted reviews of vendors; review of manufacturers' invoices, proof of payment and delivery documents to substantiate the purchase and supply of devices and services; make recommendations for improvement of the system of internal controls over vendors—

M^me^ France Gélinas: Okay. Just to target—you're going further and further away from my question. Take two: A family comes and talks to me because they've become aware that their retirement home directed them to a specific vendor and, after they've shopped around a bit, they realize they could have had the same thing at a way better price at another vendor that was not mentioned by the home, but they thought that they had to deal with the providers from the home. Can those people make a direct complaint to the verification and testing unit that you just talked to me about?

Dr. Bob Bell: Yes.

Hon. Dipika Damerla: Can I just clarify? You're talking about a retirement home and not a long-term-care home in this particular instance, right?

M^me^ France Gélinas: It makes no difference; I get complaints from both.

Hon. Dipika Damerla: Okay. Did you want to finish?

Dr. Bob Bell: Yes. I was coming to that. The accounting policy and financial reporting branch work with ADP to document all the steps and controls in place in ADP's claims processing payment to ensure funding is available and provided only to those clients who are eligible to receive it, and also to review—if clients are in a particular residential program like retirement homes and long-term care, ADP's policies specifically state that the program will not enter into or maintain a current vendor agreement with any vendor who has a financial relationship or an exclusive relationship with a long-term-care home if the vendor and the long-term-care home share in any profits made by the vendor's sale of devices funded by the program.

Additionally, the vendor shall not pay any fee or amount or give any benefit directly or indirectly to a long-term-care home that's responsible for identifying a resident's need for a device.

At the same time, long-term-care homes may prefer to establish preferred-vendor agreements in order to minimize the number of external people accessing the home, for reasons such as resident safety and infection control.

Applicants must be given the opportunity to decide on a vendor of their own choosing. Restricting vendors from paying any fee, amount or benefit to the long-term-care home ensures that the applicant or applicant's family is provided the opportunity to decide on his or her own vendor.

M^me^ France Gélinas: That only applies to long-term-care homes. It does not apply to retirement homes?

Dr. Bob Bell: I believe it also applies to retirement homes. Yes, it does.

M^me^ France Gélinas: It applies to both. They're allowed to select vendors of record, so that they know who's coming into their homes, but there should be more than one. Did I hear that correctly?

Dr. Bob Bell: Let me double-check on that. I think that's the case. Yes, it is the case.

M^me^ France Gélinas: It is the case. So if they have a vendor of record that they recommend to their families, there should be more than one, and they should give a choice.

Dr. Bob Bell: Certainly, there can be no collusion payments of any type between the retirement or long-term-care home and the vendor.

M^me^ France Gélinas: Okay. So if this is not happening right now, can they call the verification—how do people let you know that there's something wrong?

Hon. Dipika Damerla: If you're suggesting that there's a long-term-care home that doesn't have more than one vendor of record, I'd like to know. If you feel that the procedures that the deputy has outlined—if for some reason you're of the opinion that they're not being followed, we'd like to know.

In principle, what the deputy was really saying is, there are a lot of checks and balances, primarily because there can be no fiduciary relationship between the vendor and the long-term-care home, essentially.

The second piece is, we reimburse the resident directly, so the resident always has the choice of going with the vendor they want. They always have the choice of shopping around. Then they submit their receipts to us. They submit the original application to us; right?

M^me^ France Gélinas: I don't want people coming through me to get to you, so the answer is I can direct them to you, if you want. I'm not sure you would like that.

Hon. Dipika Damerla: Is there a process? Why don't you come and answer that?

Dr. Bob Bell: This is Patricia Li, from our assistive devices program.

Ms. Patricia Li: Hi, I'm Patricia Li. We have a hotline for the ADP program which we can certainly provide to you. As well, it's on the website. Patients often call that number to register complaints and ask for general inquiries.

Any complaints to the program, we can use that number, and we will either use the verification unit to do more audits, or we do our own investigation.

M^me^ France Gélinas: Thank you. All right. I'm moving on. This morning, I had asked about the paramedics program. I was wondering if that person is available.

Hon. Eric Hoskins: She is, and we have the answer, I believe.

M^me^ France Gélinas: Okay. Do I need to repeat the question, or do you remember?

Dr. Bob Bell: No, we have that answer right here, and if it's not sufficient, I'll ask Patricia to comment.

The basic life support patient care standard is the ministry standard, which sets out the minimum mandatory level of care provided by paramedics in Ontario, including the requirements paramedics must follow in terms of conduct, patient assessment, patient management and patient transportation.

In 2014, work began on a full revision—which I think is what you were referring to—to the basic life support patient care standards, to prioritize amendments, led by ministry representatives and the medical director of Sunnybrook base hospital.

This preliminary comprehensive work resulted in a draft, to be circulated for stakeholder review. Broader stakeholder consultation began in October 2015 in the form of a working group consisting of medical and operational experts. Extensive revisions have been made to the standard, to ensure that Ontarians receive the best care from paramedics that is evidence-based.

As of May 31, 2016, the basic life support patient care standard has been fully revised and reviewed by the working group, with all stakeholder feedback resolved. However, due to the fact that it is directly referenced in regulation 257/00, as made under the Ambulance Act, there are additional legal considerations such as alignment with other acts—for example, the Personal Health Information Protection Act—and standards such as the advanced life support patient care standard. As such, it's currently with our legal services branch for final review.

In a December correspondence, the ministry indicated that the basic life support patient care standards would be released in early 2016, which I think you referred to. Due to the substantive content changes and alignment considerations to other provincial standards and legislation, and related complex stakeholder discussions regarding implementation, the release date is now within the next 60 days, likely July 2016. The delayed release will ensure that training, operational and logistical procurement considerations are taken into account for continued patient safety.

Interjection.

Dr. Bob Bell: I'm told that July 2016 may be a bit further delayed, and that standards are ready to be released in the next few months.

M^me^ France Gélinas: Very good. Thank you. Can I have assurance that oxygen administration and spinal immobilization are both going to be part of whatever rolls out in July or shortly thereafter?

Dr. Bob Bell: Sorry, say that again? I didn't quite catch it.

M^me^ France Gélinas: That oxygen administration—

Dr. Bob Bell: Oxygen administration.

M^me^ France Gélinas: —and spinal immobilization will both be part—

Ms. Patricia Li: Yes.

M^me^ France Gélinas: To both?

Ms. Patricia Li: Yes.

M^me^ France Gélinas: Very good. Thank you. I'm going into hospital procurement, just so that everybody follows along. First, I would like a copy of all the reports into investigations conducted at St. Mike's, St. Joe's and Markham Stouffville, and if the reports are not ready, just to know when we can expect them to be completed.

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There was a report in the Globe and Mail this February that talked about such a report, but I was wondering if there was more than just the one report, and if there was more than one, if you could share them.

Hon. Eric Hoskins: Could you just remind me of the hospitals again? I apologize.

M^me^ France Gélinas: St. Mike's, St. Joe's and Markham—

Hon. Eric Hoskins: Stouffville.

M^me^ France Gélinas: Stouffville, yes.

Hon. Eric Hoskins: Okay. I can certainly look into that with the ministry.

M^me^ France Gélinas: Okay. My second, still on hospitals: Can we get the report from Infrastructure Ontario's investigation that you announced last fall into the alleged procurement fraud and possible cover-up—that's what the announcement was—involving a senior procurement official at St. Mike's, and the report by William Braithwaite—I'm not sure how to pronounce his name; B-R-A-I-T-H-W-A-I-T-E—who was your ministry observer at the investigation? And if it is not completed, when do you expect this report to be completed?

Hon. Eric Hoskins: I was just conferring on that. That may be a matter more germane to the Ministry of Economic Development and—what is it called these days?

Interjections: Economic Development, Employment and Infrastructure.

M^me^ France Gélinas: Brad Duguid.

Hon. Eric Hoskins: That being said, I'll look into that with the ministry as well, to see whether it is something within our purview or whether it would be better addressed through another ministry.

M^me^ France Gélinas: Okay, because the clippings that talked about this project identified Mr. William Braithwaite as your ministry observer in this investigation at St. Mike's—not infrastructure, but the Ministry of Health and Long-Term Care.

Hon. Eric Hoskins: My understanding is that this individual was not in fact employed by our ministry, but rather was employed by Infrastructure Ontario. But I'm happy to have further discussion with the ministry.

The Chair (Ms. Cheri DiNovo): Madame Gélinas, you have about two minutes left.

Hon. Eric Hoskins: Certainly we'll follow up, and I will commit to looking at that with the ministry.

M^me^ France Gélinas: Okay. Sort of in the same line: According to the sunshine list, Vas Georgiou earned $429,000 and change from St. Mike's in 2015, up by about $37,000 from what he earned in in 2014. Of course, he did not work a full year in 2015. Was Mr. Georgiou paid a severance? And what is the status of his wrongful dismissal lawsuit?

Hon. Eric Hoskins: The ministry—or at least certainly the deputy and myself—are not familiar with the terms of his departure, but I'd be happy to look into that with the ministry as well.

M^me^ France Gélinas: Okay. In the same line of thought: What is the status of the lawsuit filed by the Ottawa Hospital in connection to allegations of procurement fraud?

Dr. Bob Bell: As far as I know, that's being pursued through the courts. We don't have any recent update as to the suit, either the civil suit brought by the hospital or possible further criminal investigations.

M^me^ France Gélinas: Is this something that the ministry follows, or is it something that you leave completely in the hands of the hospital?

Dr. Bob Bell: Certainly, in terms of the Ottawa Hospital, as you know, the allegations of fraud were discovered through an internal audit process undertaken by the Ottawa Hospital, where potential wrongdoing during procurement was discovered and investigated and a suit was brought by the hospital against contractors who had undertaken the services allegedly inappropriately procured. That suit was brought. We learned about that immediately, when the internal audit discovered potential wrongdoing. There was a complete discussion of what had occurred. We were informed before the employees—

The Chair (Ms. Cheri DiNovo): Thank you, Dr. Bell. I'm afraid the time is up now for the third party. Thank you, Madame Gélinas.

We now go to the official opposition. Mr. Yurek.

Mr. Jeff Yurek: I guess we'll just go back to my question regarding the Ontario lottery fund's $107-million reduction for the operation of hospitals. If you could just let me know what went on and what the fund is actually used for. I can't find that anywhere.

Hon. Eric Hoskins: Okay. Thank you for raising that question again. As I think you know, revenues generated by OLG are paid directly into the province's Consolidated Revenue Fund, and then allocations to the Ministry of Health and Long-Term Care are made from that Consolidated Revenue Fund itself.

As a reference point, the OLG revenues that are targeted for health care only amount to about 3% of our total budget of $52 billion, so fluctuations in OLG revenues do not impact health care funding levels or projections. Certainly, the Minister of Finance, I think, would be in a better place to address any inquiries specific to OLG revenues. But for 2015-16, I can say that—I think I can say?

Interjection.

Hon. Eric Hoskins: It's here in front of me, and I'm going to say it. OLG's revenues for 2015-16 ended up

being higher than what they were projected in budget 2015. As a result, the OLG revenues for 2015-16 set out in budget 2016 are higher. For 2016-17, OLG has projected that revenues will likely return to normal levels. The understanding is that there were factors that took place in 2015-16 with regard to OLG revenues that perhaps were one-off, that they anticipate may not happen in the future. That's why the revenues for 2016-17 seem lower, but really, OLG is just projecting them at what historically have been normally anticipated levels.

All that is to say that we receive our allocation—about 3% of the whole—through the Consolidated Revenue Fund, which is where OLG deposits the revenues that they receive. Any fluctuation in the OLG revenues itself does not impact our revenue or our projections.

Mr. Jeff Yurek: I'm just trying to follow your interesting description. So $100 million less is slated for the operation of the hospitals from the consolidated revenue? Is that what I'm understanding here?

Hon. Eric Hoskins: Yes, I think—do you want to help with this?

My understanding is that in the prior year, there was an increase in OLG revenue that led to a reflection in the budget, but perhaps—

Mr. Mike Weir: Yes, thanks. Mike Weir. I'm the assistant deputy minister for the corporate services division.

The OLG revenues are part of a multitude of revenues. In fact, if you look at the budget on page 282, you can see a myriad of different revenues that go into the Consolidated Revenue Fund, as the minister has indicated, from which allocations to ministries occur. Those are the sources of the funds.

The exact amount is notional in nature. We don't get, penny for penny, the amount that is listed in the budget table that you indicate, but it does comprise part of the overall allocation to the ministry.

I called the Ministry of Finance this afternoon. This is a Ministry of Finance table—it's not a health table—so they may be in a better position to describe exactly the mechanics of how that works. They do tell me that the revenues are up in 2015-16. There are a couple of reasons for that, and it's probably not my place to say; it's probably better theirs. But because there were some high jackpots last year, that incented more ticket purchases, and because of a milder winter, they say that that incented or resulted in more people going into gaming places, which resulted in higher revenue. They have no way to predict whether or not that's going to occur again, and therefore have projected revenues back to what has been historical.

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Mr. Jeff Yurek: How much was allocated from that fund to hospitals last year, and how much is budgeted for this year?

Mr. Mike Weir: Again, I'd have to say that I can't give you an exact number in terms of what's allocated. These are notional allocations. Our budget is made up of an overall allocation for which these revenues and a whole host of other revenues comprise part of the government's ability to fund ministries.

Mr. Jeff Yurek: So you have no idea how much money is coming from OLG into the hospitals? One hundred million is a lot of money not to be able to know where it's going. Considering $300 million added to hospitals, $100 million out of hospitals—that's what we're trying to find the answer to.

Hon. Eric Hoskins: Again, it represents 3% of our total budget. But I think if there's a year that stands out, it's the prior year, where notionally there was an increased transfer to health, if I understand it correctly, out of the OLG revenue. This year, in terms of the plan and what is reflected in the budget, is actually a return to closer to what historical projections have been.

That being said, if we have some big jackpots again this year and if we have a mild winter, we may actually see that there's an increase in revenue, but my take on it is that they've returned to historical projections, understanding that last year, not this year, was a bit of an aberration.

Dr. Bob Bell: But to be clear, there is no change in the allocation to the Ministry of Health. The notional allocation to the health budget from Ontario lottery revenues is in this Ministry of Finance table. The allocation to the Ministry of Health is consistent, no matter what the weather and the jackpot earnings are in 2016-17. The Ministry of Health allocation is as printed in our estimates, not related to the revenue sources that might come from OLG.

Mr. Jeff Yurek: Do you have the allocation numbers from years previous that you could share?

Mr. Mike Weir: I don't have the allocation to the health budget, but I can tell you that in 2014-15, the interim forecast for OLG revenues was $2.171 billion, versus the 2015-16 plan at $2.155 billion.

Mr. Jeff Yurek: Can you get me the numbers for operations for hospitals for 2014-15 and 2013-14 so I can see the trend and the little bump that occurred?

Mr. Mike Weir: We can ask the Ministry of Finance if they can provide us with that information.

Mr. Jeff Yurek: So basically what I'm hearing is that the funding to hospitals is coming from the Consolidated Revenue Fund, and it's just whether or not that money that filled the fund came from lottery or from some other source in the government. Is that basically it?

Mr. Mike Weir: That's correct.

Mr. Jeff Yurek: I've just got to ask my questions so that I get an answer I can comprehend.

Back to the behavioural supports: When I asked for a breakdown, did you get that, Associate Minister?

Hon. Dipika Damerla: Sorry?

Hon. Eric Hoskins: The behavioural supports breakdown.

Mr. Jeff Yurek: You said maybe 70-30 or 80-20.

Hon. Dipika Damerla: As I mentioned this morning, we'll endeavour to get back to you.

Mr. Jeff Yurek: You haven't got it yet?

Hon. Dipika Damerla: No.

Mr. Jeff Yurek: Okay.

If we go to page 57 in my book here, the 2016-17 estimates have salaries and wages at $2.3 million. The interim actuals were $4.1 million from last year, whereas the estimates were also $2.3 million. Are we expecting the actuals to be $2 million more at the end of this year, or what's happening there? It's kind of a blip.

Dr. Bob Bell: I think it's fair to say that since the interim actuals for 2015-16 and the actuals for 2014-15 appear to be about the same, we would expect the actuals for 2016-17 to follow the same course.

Mr. Jeff Yurek: So you're saying it will probably be about $2 million more, then?

Dr. Bob Bell: I think so, looking at the historical trend—yes.

Mr. Jeff Yurek: Okay. So there has been no staffing change? You're lowballing the estimates?

Dr. Bob Bell: We're not lowballing the estimates, but we are overexpending the estimates; you're absolutely right.

Mr. Mike Weir: Again, there's a bit of a technical nuance to your question here in that this is for the main office, which supports the salaries of primarily political staff. Once the number of staff and the salaries are confirmed by Cabinet Office, we will get a chargeback for that amount which will bring it up to the actual number that the deputy has described. We just don't have it yet. That number will be an end-year adjustment.

Mr. Jeff Yurek: Okay.

Mr. Mike Weir: But as the deputy describes, we can count on that being very close to what the actual was last year.

Mr. Jeff Yurek: Would that be the same answer to why the services have the blip as well, the $400,000 difference?

Mr. Mike Weir: Yes.

Mr. Jeff Yurek: Okay.

On page 76, the 2015-16 estimates for the ministry administration program audit services were $1.8 million, but the interim actuals were $3.1 million. Can you explain the difference of $1.2 million?

Hon. Eric Hoskins: Mike, we're probably going to need you back up here.

Dr. Bob Bell: This is the Ontario Review Board you're referring to, Mr. Yurek?

Mr. Jeff Yurek: Yes.

Hon. Eric Hoskins: Sorry, the line that you were referring to was—

Mr. Jeff Yurek: Administration program audit services. Is that on there?

Hon. Eric Hoskins: No. This is page 76?

Dr. Bob Bell: Pages 75 and 76 cover the administrative expenses of the Ontario Review Board, looking at the status of accused people found unfit to stand trial or not criminally responsible.

Mr. Jeff Yurek: Maybe I've got the wrong page here.

Go ahead.

Dr. Bob Bell: Again, that probably has a degree of variability based on the cases reviewed during the year, if I'm not mistaken, Mr. Weir, in that there would be a degree of variability based on the work that this review board undertakes.

Mr. Mike Weir: Yes, that's correct as it applies to the Ontario Review Board. But Mr. Yurek, I believe your question—at least what I thought I heard—was with respect to internal audit.

Mr. Jeff Yurek: Program audits.

Dr. Bob Bell: Sorry, which page?

Hon. Eric Hoskins: Page 74.

Mr. Jeff Yurek: Page 74? Perfect.

Dr. Bob Bell: Yes, audit expenses are page 74.

Mr. Jeff Yurek: Yes, that's it. That guy should work in my office.

Mr. Mike Weir: The internal audit staff are actually staff of the Treasury Board Secretariat, so every year, when we develop an audit plan, they then build a resource plan around that. If you look at the 2014-15 actuals, again, it's a similar answer to the one I gave you the last time versus the interim actuals of 2015-16. Once our audit plan is complete, we will have a better understanding of what the forecast will be for 2016-17. It will be very close to what the actuals are.

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Mr. Jeff Yurek: Okay. Thank you.

Just dealing with hospital benefits, hospital employees lose their benefits when they turn 70: Is that true? It's what we've been hearing from—

Dr. Bob Bell: I thought it was 65.

Hon. Eric Hoskins: We'll have to discuss that with ministry officials.

Mr. Jeff Yurek: Okay. You'll get back to me on that.

Dealing with the Ministry of Health, while you find that number for me: Can you give me the total cost of the upper level of Ministry of Health—the deputy, associate deputy and assistant deputy level positions? Can you give me the total cost of what that's costing the system, the expense? So staff and benefits, etc.

Dr. Bob Bell: We can look into that. We don't have that number here.

Mr. Jeff Yurek: You'll look into that for me? Okay. How many ADMs do we have now?

Dr. Bob Bell: Is anybody not here? Let me just count them.

Laughter.

Mr. Jeff Yurek: Stand up.

Dr. Bob Bell: It's 16.

Mr. Jeff Yurek: Okay. Just refer me again to the cost of running the LHINs. Was it $90 million, or is it more?

Dr. Bob Bell: Roughly in the right ballpark.

Hon. Eric Hoskins: Yes.

Dr. Bob Bell: The estimate for 2016-17 is $92 million.

Mr. Jeff Yurek: The per cent increases in hospital budgets outside of the last four years of being frozen, from 2008 to 2012: If we're able to get a chart showing the increases in hospital budgets—

Dr. Bob Bell: Total hospital budgets?

Mr. Jeff Yurek: Total would be great, if you're able to do that, and also at the same time, the total given to CCACs during that time.

Dr. Bob Bell: During that time? Sorry, what were the years again, Mr. Yurek?

Mr. Jeff Yurek: From 2008 to 2012 would be great.

The Chair (Ms. Cheri DiNovo): Mr. Yurek, you have about two minutes left.

Mr. Jeff Yurek: Two minutes?

The Chair (Ms. Cheri DiNovo): Two minutes and a bit.

Mr. Jeff Yurek: The health innovation funding: Is that a new funding that is recent? How many projects have received funding as of yet?

Hon. Eric Hoskins: Pardon me?

Mr. Jeff Yurek: With the health innovation funding, how many projects have been funded?

Hon. Eric Hoskins: How many projects? It's a relatively new fund that was implemented last year. Bob, go ahead.

Dr. Bob Bell: Just double-checking.

Hon. Eric Hoskins: We're just double-checking in terms of the numbers that have been funded thus far. This is associated with Bill Charnetski, who's the new health innovation strategist.

Mr. Jeff Yurek: Right.

Dr. Bob Bell: Please let us look into that, if we may.

Mr. Jeff Yurek: And if you get me the costs associated with the program, as well.

Dr. Bob Bell: The total allocation to that program over a period of three years is $20 million.

Mr. Jeff Yurek: It's $20 million?

Interjection: Over four years.

Dr. Bob Bell: It's $20 million over four years. Of course, this is designed to stimulate innovation in the health procurement sector, as well as supporting Ontario enterprises and contributing to economic development and employment by stimulating innovation in service provision and in device development here in the province, as well as encouraging international companies to undertake testing of new technologies in the Ontario health environment, providing jobs to clinical trial organizations, nurses, which is both good for Ontario patients, getting access to new technologies earlier, and also providing great jobs to the staff who provide clinical trial testing within the province.

Mr. Jeff Yurek: The $20 million is to run more than just the projects; it's also running the staffing to generate the—

Hon. Eric Hoskins: If you'll allow me: The creation of the Office of the Chief Health Innovation Strategist itself as well is, I would say, probably the next priority recommendation that came from the Ontario Health Innovation Council, which was a council primarily of private sector leaders together with government and other individuals. They came up with a number of recommendations as a result of about a year of study of this issue, of how we could do better as a government and across government on health innovation and adopting technologies within the province and promoting their use outside of the province. The creation of that office was their number one recommendation—

The Chair (Ms. Cheri DiNovo): Minister, if you could just wrap up that sentence, your time is up.

Hon. Eric Hoskins: I think the second most important recommendation was in fact the creation of this fund to further spur innovation and allow for its adoption.

The Chair (Ms. Cheri DiNovo): We now move to the third party. Madame Gélinas.

M^me^ France Gélinas: Thank you, Chair. Actually, I would ask a question of you, if you don't mind. We've all received a copy of a document, dated May 20, which is called "Estimates Committee Hearings, Ministry of Health and Long-Term Care," and it's a list of outstanding questions. Are there any timelines, within the standing orders or otherwise, for those questions to be answered?

The Chair (Ms. Cheri DiNovo): It's entirely optional for the government to commit or not to commit to answer your questions in estimates. There's no standing order regarding timelines.

M^me^ France Gélinas: All right.

I will turn to you, then. Is there a commitment to answer the outstanding questions as put together by our researcher on May 20?

Hon. Eric Hoskins: We'll certainly see what we can do for you.

M^me^ France Gélinas: Sounds good. Thank you.

Again, Deputy, you were in mid-flight, explaining to me the allegations of procurement fraud at Ottawa Hospital and the relationship between what had happened at the hospital and to the ministry. I didn't know if you wanted to finish that.

Dr. Bob Bell: I think I had finished. As I mentioned, this was an allegation of fraud that was discovered by the hospital through its internal audit processes, immediately disclosed to the ministry—as well as the subsequent action undertaken with respect to its employees and also the action brought against the contractors who had provided services that were thought to be improperly procured. So we knew about that every step along the way.

M^me^ France Gélinas: Drilling down on this, they are going through a court process. Hospitals don't usually have the resources to take on elaborate court challenges of their own. If they get sued, they have protection, but when they initiate court proceedings, where does the money come from for them to be able to bring this to court?

Dr. Bob Bell: My understanding of the case brought against the contractors is it is actually supported—and we'll find out if this is the case for sure—by the Healthcare Insurance Reciprocal of Canada, since there is an opportunity to recover funds that were expended based on potentially inappropriate procurement. I believe those civil suits are being supported by HIROC.

M^me^ France Gélinas: To another hospital: In the Mackenzie Vaughan redevelopment project, why did Vaughan feel dropped out, and what do you do when a

hospital that is under the P3 procurement process only ends up with two bidders rather than three? Has this happened before? Do you let it go forward? What happens?

Dr. Bob Bell: We've had reliance on Infrastructure Ontario to undertake procurement of the major hospital capital projects, including the one that you're describing. In terms of why a proponent would drop out of the procurement process, I can't comment on that. I don't have information with respect to that. Our health capital branch has regular discussions with Infrastructure Ontario regarding the process and procurement. We were assured by IO that the two proponents bidding on Mackenzie Vaughan provided an adequate process, an appropriate process. They thought that this was an appropriate procurement.

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M^me^ France Gélinas: Okay. I'm changing areas completely and talking about physicians and physician recruitment. We have a return-of-service process which is a part of a package of government initiatives designed to attract and retain physicians in communities across Ontario, including the communities that I represent. Within this, you have the ministry fund for re-entry training positions, in exchange for a commitment for returns of service on a full-time basis for two years in any Ontario community.

I'm assuming that somebody in here is knowledgeable about this. You are required to return service in the specialty area in which you will be trained in the re-entry program. How can I find out, first, how many physicians took part in this program in the years since the new government initiative started, and how many of those who did enter this program actually completed their two years in a community?

Then, the most important questions in my lineup of questions are: What happened to those physicians who did not complete their commitment? Do we get our money back? How much money did we get back?

Dr. Bob Bell: So we don't have exactly the numbers. Maybe I can ask Assistant Deputy Minister Denise Cole to respond to what happens if return of service is not achieved.

M^me^ France Gélinas: Okay.

Ms. Denise Cole: Good afternoon—

The Chair (Ms. Cheri DiNovo): Could you state your name, please?

Ms. Denise Cole: Yes, I will. I'm Denise Cole.

The Chair (Ms. Cheri DiNovo): And thank you for moving the chair around. It is traditional to sit there. Thank you.

Ms. Denise Cole: I'm Denise Cole. I'm the assistant deputy minister in the Ministry of Health for the health workforce planning and regulatory affairs division. Part of my basket of responsibilities is the funding of clinical education, and the Return of Service Agreement falls within my portfolio.

I don't have the exact number for the participants since the inception of the program, but we will get that to you.

With regard to the participants who signed the agreements, it is for the international medical graduates, and it is a commitment that they make, that we will provide the financial support, them with the commitment that they will go to an underserviced area. The areas are determined by the rural index.

There is an option in the program that if, due to labour market conditions, the participant cannot find a job in that area, their payment can be waived for a period of time.

Those who do not pay back: We do go after them for the money. Either we go after them ourselves or we use the services of a collections agency to have the debt repaid.

M^me^ France Gélinas: Looking at the estimates, I realize that it would be a small amount, and most of the amounts in there start in the millions. If I wanted to find out how much money we ever recovered from physicians who did not complete their commitment, is there a way to drill that down anywhere?

Ms. Denise Cole: Not in the estimates document. We would have to pull the numbers through the HealthForce Ontario Marketing and Recruitment Agency, because they do have a role to play in the Return of Service Agreement, and also within my division.

M^me^ France Gélinas: In your knowledge of doing this work, are you aware of your ministry ever going after repayments from physicians who did not complete their commitment?

Ms. Denise Cole: Oh, absolutely.

M^me^ France Gélinas: You are?

Ms. Denise Cole: Oh, yes. We are quite dogged in our pursuits of making sure that the physicians are living up to the obligation and, if they don't, we do recover it.

M^me^ France Gélinas: Does this happen every year?

Ms. Denise Cole: Oh, yes. I have a staff person within my division, and all that they do is keeping track of the agreements and the status of the agreements. There is an obligation for reporting and it's done on an annual basis.

M^me^ France Gélinas: I appreciate your willingness to try to find those numbers for me. That would be helpful. If you can also find the money recovered, that would also be helpful. Thank you.

Ms. Denise Cole: And the dates you had asked for, again?

M^me^ France Gélinas: Well, it was sort of a new package that the government put together from the time it started—

Ms. Denise Cole: From inception?

M^me^ France Gélinas: Yes.

Ms. Denise Cole: Okay.

M^me^ France Gélinas: Thank you. My next question has to do with small and rural hospitals. Minister, I had opportunities in the House to ask questions, and you answered me on a number of occasions where you talked about the Small and Rural Hospital Transformation Fund and the dedication fund of $20 million annually that goes to small and rural hospitals. I know about this fund and so do you, and all is good.

This is the conversation we are having here, but when I talk to our small hospitals in northeastern Ontario, they're being told that they should wrap up the plans for this fund, that it is coming to an end. When they ask about a multi-year horizon for a project, they are told that the fund will continue for one more year but no commitment to anything beyond that, which is in sharp contrast from how you answered me in the House.

Dr. Bob Bell: Could we ask Associate Deputy Minister Nancy Naylor to come in on this, please?

M^me^ France Gélinas: Maybe I'll make my question even sharper: Is this fund going to be permanent?

Ms. Nancy Naylor: My name is Nancy Naylor. I'm an associate deputy with the Ministry of Health. This funding is permanent. It's a permanent part of our hospital funding model and it is focused on small and rural hospitals, and small and rural sites of multi-site hospitals.

For the last three years, we have allocated it through LHINs to the eligible hospitals for projects that support these hospitals and their sustainability, patient care and other goals that are supportable by the advisers we have from the hospital sector and the LHIN. It has supported things like new IT systems, new quality systems, patient safety and those types of projects. In some cases, they have been used for proof-of-concept projects for things that hospitals have grouped up on. It is a permanent part of the model. That allocation has gone out on the same terms this year as it has in other years.

We are discussing with OHA and their membership that this year we have a particular focus on small hospitals. We're asking for their advice about what the best use of those projects is. Some of the hospitals have felt that they've done a lot of good projects on a one-time basis, and they'd like to discuss what other uses of that funding might be useful for them and their patients.

M^me^ France Gélinas: Okay. So what the minister had said on record is true: The fund will be permanent. So far, of the hospitals that have benefited from that fund, were they ever allowed to have more than one-year funding, as in if you had a transformation project that qualified for the fund, but it would require $5,000 this year and $15,000 next year in order for the transformation projects to be completed? Was that ever allowed, or was it always a one-year project?

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Hon. Eric Hoskins: This is one-time funding. In that sense, it's project-based funding; however, that doesn't preclude a small, rural hospital for applying multiple times over multiple years for different projects that will be assessed based on the merits of that project. This is really an important fund made available to these specific small, rural hospitals as well, but it's important to emphasize that it's intended to be one-time funding and not recurrent or operational in any sense.

M^me^ France Gélinas: I agree with what you've said. I guess my question is, can the one-time funding stretch over more than one fiscal year or is it one-time funding that has to be within the 12 months of the fiscal year?

Hon. Eric Hoskins: If you're saying a project, for example, undertaken by an individual hospital extends over two fiscal years, can they draw on the allocated funds over those two fiscal years? I think that there are a number of examples that have done precisely that.

M^me^ France Gélinas: Okay. So what is your best guess as to why the North East LHIN basically thinks that all of the projects need to wrap up this year?

Hon. Eric Hoskins: If I'm correct from what Nancy has said, that there are demonstrated opportunities where small or rural hospitals have received project-focused funding, and they have expended that funding over the course of more than one fiscal year—

Ms. Nancy Naylor: Yes. There are occasionally projects that LHINs approve that might take two years to accomplish. I'm not familiar with the guidance that the North East LHIN might have provided but we do caution hospitals not to bring it into their base funding or use it as, say, a deficit-avoidance technique. It is meant for turn-the-corner projects, or projects that really create capacity in the hospitals to be sustainable and offer high-quality patient care.

M^me^ France Gélinas: So I can go back to my community and say, "Yes, the deputy and the minister assured me that this is ongoing funding." How this funding is available has stayed the same but you are looking at it, and it could change in the future. But the amount of money is there and will continue to be there for northern, rural and small hospital sites.

Hon. Eric Hoskins: Yes, I think with a couple of provisos, as was referenced.

We're consulting currently with the Ontario Hospital Association to look at the program. I think we're in the fourth year of the program. It's prudent for us to reflect upon it and engage our stakeholders, including the OHA, to see how it might be further strengthened to be even more impactful. Then, like any allocation, it's subject to budget approval year to year. But we have certainly seen and understand the tremendous benefit of this program to these specific hospitals.

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

The Chair (Ms. Cheri DiNovo): Madame Gélinas, you have just over two minutes left.

M^me^ France Gélinas: In my last two minutes, I will talk about take-home cancer drugs. I know, Minister, that you have been taking the lead on pharmacare and have been very active on this file at the country-wide level, as well as in our province. Has your ministry ever costed out how much take-home cancer drugs would cost if they were to be covered within pharmacare? And are those estimates something you could share?

They've abandoned you, but I'm sure—

Hon. Eric Hoskins: They've abandoned me, but I'm sure if I speak slowly and deliberately, by the time I'm finished this rather long sentence, before your two minutes are up—Deputy, are we conferring on this?

Dr. Bob Bell: We're just coming back to you with a number, Minister.

Hon. Eric Hoskins: All right. I apologize for the fact that these aren't necessarily figures that we would have close at hand.

M^me^ France Gélinas: Is this something that you are looking at, that if we are to roll out pharmacare, we would start with take-home cancer drugs and then build on, I don't know, drugs for people with arthritis, and then build up other disease-specific categories of drugs? Is this something that has been looked at?

Hon. Eric Hoskins: Certainly, when I've spoken about pharmacare, I've talked about it in the context of accessibility and health equity, as well.

To ensure that those individuals in the first instance, who are unable for reasons of income or those circumstances to get access to the sorts of drugs that you're referencing—that should really be the starting point, the fact that at least one out of every 10 families, and some suggest it could be as high as three out of 10, are unable to get such access because of economic circumstances. Certainly, in the conversations that I've had as well, across this country and particularly in Ontario, when I consult with individuals and families, that issue of equity and access is probably of paramount importance.

He might have the figure—

M^me^ France Gélinas: I think he has a number for me.

Hon. Eric Hoskins: The estimate is that it would be probably in the order of just over $300 million.

M^me^ France Gélinas: And that would be to cover taking—

Hon. Eric Hoskins: Oral chemotherapy drugs.

M^me^ France Gélinas: Oral chemotherapy, at home?

The Chair (Ms. Cheri DiNovo): And with that, I'm afraid your time is up, Madame Gélinas.

We now move to the government side for 20 minutes: Ms. Naidoo-Harris.

Ms. Indira Naidoo-Harris: My question is for the Minister of Long-Term Care, Minister Damerla.

Minister, during my university years, especially the first two years, I had the opportunity, as most young people do, to have summer jobs. I lived in a small town in Alberta at the time, and the main facility there was an auxiliary home and also a long-term-care facility. During my first two years at university, at the age of about 17, I was actually spending time, in two summers, going back every year and working at the local auxiliary hospital and long-term-care facility.

My experiences there were very interesting. I worked with seniors and saw first-hand, of course, the demands and challenges of the job. I became very aware of and sensitive to the fact that taking proper care of our seniors can be complicated and, of course, hard work. It was also clear to me that seniors often require vigilance—constant vigilance—in order to make sure that they are okay and that they are being well taken care of.

Our seniors, who are usually our parents and our loved ones, are also often vulnerable as they age, as I know you're aware, and I am too. So it is increasingly important that, as people age, we are vigilant in ensuring that we're looking after them properly, that they are okay and that they are safe, because they often lose the ability to communicate properly and they can't always help themselves, when they have had a fall or they're in a situation, to get up.

At that time, I learned early on that it's important to ensure that our long-term-care residents get quality care. I know that the safety of our long-term-care residents is incredibly important to you and important for Ontario families. We all know, and want to know, that our loved ones are being properly taken care of and living in safe, comfortable conditions.

I know that the Long-Term Care Homes Act sets important requirements for long-term-care homes with respect to LTC residents' rights and protections, and service requirements, accountabilities and system management. I think most Ontarians have confidence in these standards but may have more concern about the government's ability to consistently enforce them. That's why it's fundamental, I think, that the government carries out proper inspections of our long-term-care homes.

Minister, can you please provide this committee with information on just how exactly the ministry inspects long-term-care homes and the different types of inspections that occur?

Hon. Dipika Damerla: Thank you, PA Naidoo-Harris. I really appreciate your sharing the fact that you actually spent some time, as a student, working in both a hospital and long-term-care homes. The one thing I know is that a lot has changed since then, here in Ontario.

One of the things that is the founding principle of the Long-Term Care Homes Act is that the long-term-care facility is the resident's home. If it is somebody's home, they ought to feel safe, and they ought to be treated with dignity. So that is the holistic principle around which the entire act is predicated, which is that the long-term-care home is indeed somebody's home. As you very correctly pointed out, the inspection system is a key part of ensuring that our long-term-care residents are safe.

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But before we get to inspections, I do want to say one thing, which is that one of the greatest privileges in the past two years has been the fact that I've visited so many long-term-care homes across Ontario, and the one thing that I've been so impressed with is the dedication of the front-line staff. I've said this before. We can't legislate that feeling of, "I need to look after this person with dignity." We can legislate this and we can legislate that, and you have to do this and you don't have to do that, but that human interaction can't be legislated. That human interaction comes from leadership within the sector, as well as us as a province valuing the work of the front-line people in long-term-care homes and across the health care sector. I think that the Premier has shown great leadership when it comes to that.

That's a really critical part. If we want our long-term-care residents to feel safe, then the people around them who provide that care—that we value them, that they're well trained and that they have the resources they need to do their work—we really appreciate that.

Coming to inspections, I do have to say that we are probably one of the few provinces across Canada that has

such a robust inspection system. You asked me about the types of inspections, and I'm going to ask my ADM at some point to join me to give you a real detailed breakdown, but I would say that primarily, one of the really important things about Ontario's inspection system is the fact that we have mandatory inspections.

We have inspections that are reactionary. Somebody—it could be the home, it could be a resident or it could be a family member of the resident—might call in to the hotline and make a complaint, and then that would trigger an inspection. But on top of that, we also do mandatory unannounced inspections. That is really a key part of our quality control, because they are unannounced and they're mandatory; what that means is that every single home gets at least one inspection from the province.

One of the things that I do say often which is really important—I want the committee to understand this—is that being able to do these mandatory inspections has had so many benefits, including the amount of data we can collect. It has also taught us what the good homes do really well. That has been a key learning, because to know what it is that our good homes do well—when we go into an inspection we are able to learn that and then use all of that learning. So the mandatory inspection is just such a key, fundamental part of our inspection process, and we are very proud of it.

I want to thank my team. This is our third year, so we are well into the process. We've done two full years of mandatory inspections. This will be our third year of mandatory inspections. I can just tell you that the ministry has done a great job of doing all that we need to scale up and have the capacity to do these inspections.

Now I'm going to turn it over to ADM Nancy Lytle, because she will have more to add on this.

Ms. Nancy Lytle: Thank you, Minister Damerla, and thank you, Madam Chair, for the opportunity to be here this afternoon. As indicated, my name—

The Chair (Ms. Cheri DiNovo): Could you—oh, sorry. Go ahead.

Ms. Nancy Lytle: My name is Nancy Lytle. I'm with the Ministry of Health and Long-Term Care and I'm the assistant deputy minister for long-term care. In that purview, falling under my division, is the long-term-care quality inspection branch. I'm pleased to share a bit of detail with committee members today about what that program does to ensure the rights of residents living in long-term care, and also to protect them in their vulnerable circumstances.

You've heard both ministers and a number of my colleagues reference that approximately 78,000 residents live in long-term care, and they live in approximately 630 homes. We really are, as a ministry and as a government, very committed to ensuring that those residents' rights, safety and quality of life are protected and promoted. That, in fact, is why the Long-Term Care Homes Act was implemented.

If I could spend a couple of moments referencing the Long-Term Care Homes Act and its regulation and its proclamation in July 2010 as a flagship piece of legislation that really is the main legislative authority for safeguarding those residents' rights, as I referenced, and improving the quality of life for those residents, and also holding the accountability for long-term-care homes in providing services and care and treatment to those over 78,000 residents. The act sets out the ministry's most important requirements with respect to long-term-care residents' rights and protections, establishing service requirements, accountability system management, as well as setting those expectations for inspection and compliance. The regulation provides the details necessary to carry out the act. That is why from an inspection perspective we're continuously improving, as part of that comprehensive inspection program, both the implementation and the delivery of those inspection services.

It's interesting because the act was proclaimed almost six years ago, so we've done a considerable amount of work in operationalizing and implementing those inspection services. It is important to note that we do hold, as does the act, the long-term-care home operators accountable by ensuring their compliance with legislation and with the legislation that governs their homes.

You would have heard the minister reference a commitment to a mandatory or an annual inspection process. Those are called resident quality inspections. The government made a commitment to having those implemented annually in every home in Ontario in 2013. That's ensuring, in essence, that every home has not just a follow-up critical incident or complaint inspection but that comprehensive inspection. The commitment was that by the end of 2014, every home would be inspected and every home thereafter—and I'm happy to say that for the second consecutive year, we have done those inspections in each and every long-term-care home, and we're now cycling into, again, as the minister referenced, the third year of that inspection process.

Why a resident quality inspection, and a bit about what a resident quality inspection is: Resident quality inspections are conducted using a fairly prescribed methodology. The methodology itself was derived from a US-based quality indicator survey system. When we looked at, as part of implementing the act, what tools were available to Ontario for consideration for implementation, the quality inspection information system was one of those systems. At that point, it was about 85% compliant with the legislative expectations under our act, so it was very easily adaptable for application in Ontario. What was unique to that system, and remains unique to the Ontario system, as the minister also referenced, is that it does focus on resident quality and on their care during their residency in a long-term-care home. Inspectors complete these in-depth inspections and focus on areas of identified risk. In addition, there's software that accompanies the application of these tools so that they can capture information during the inspection process, and that helps them produce their inspection reports which, as the minister would have referenced, not only informs us about the resident quality inspection and the performance

of the home, but we can roll up and take a bit of a systemic view into the system once we've completed all of the inspections in every home.

The interesting application of the resident quality inspection is that it begins with a series of residents, with residents, which is really key and critical to that quality of life that I've referenced throughout my remarks today. It also considers input from families and direct observations in the home about how care is being delivered and a thorough review of plans of care and records in the home to match up all of the information and data they're collecting. Accompanying the software, the methodology, there's also a series of protocols. There are 33 protocols that are used to develop the lines of inquiry, again, as I referenced, on a risk-based approach. They really do guide and focus on care services and operations and they guide the inspectors to support consistency of application, because it's important from a program perspective and quality of inspection, quite frankly, that we're using those standardized tools and consistent methodologies in applying the inspections. As referenced, those inspections focused on the needs of the residents. They follow that consistent methodology and provide a robust, end-to-end perspective of a home and its operations.

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We have other forms of inspections that I've referenced as well: complaint inspections, critical incident inspections and follow-up inspections. They follow the same principles of those comprehensive inspections, but they are, as you might intuit from the title of the inspections themselves, much more either incident-driven, complaint-based or critical incident reported. It's also really important, from our perspective, to note that the legislation requires that regardless of the kind of inspection that we're conducting, all of our inspections are unannounced. So when we arrive at any home, it is without any advance notice or warning to that home.

The inspection program also, during that transition period and up to today's application of the program, has moved from a paper-based system to a manual, fully automated system. While we were growing the program, conducting all of our inspections and building the ship, if you will, we were also transitioning on every aspect of the program level.

We also, as you can appreciate, leading up to the introduction of the act, did a great deal of outreach with the sector in training them and in sharing methodologies with them, so that, again, homes are fully informed before we arrive about what it is, particularly during those residence quality inspections, that we're going to be looking for.

We also focused some in-depth training services for both our inspectors and leadership team as well. I think, again, you can appreciate around the table that to introduce that quantum of change, it took a great deal of training and focus to do so.

A key component to the program also includes transparency. As I like to say, on any given day in Ontario there are probably about 15,000 of our inspection reports online and available for public viewing. That's really important because it's the inspector's role to ensure that all homes are compliant with the act. The inspectors are given specific legislative authority to perform those duties. Part of those duties includes the completion of an inspection report, which is eventually posted online. You can appreciate, I'm sure, that for the public version of the report, any personal health information is removed from it so that there is not any ability to identify the resident who is being inspected.

It's also important, when you think about the whole end-to-end quality of resident care, that those inspection reports are also shared with family councils and resident councils. It's a nice completion of that transparency that gives full access to all those impacted to the information that they need.

In circumstances where homes aren't compliant or there are some issues identified through any manner of those inspection reports, inspectors are empowered to find what we call non-compliances. The inspectors are also given authority under the act to decide what action, or sanction, to take with respect to the home. But the legislation sets out three key factors that determine what course of action the inspector will take: the severity of the non-compliance found, the scope of the non-compliance and the compliance history. In other words, you're putting it in the context of the home's overall performance and the severity of the instances. A good example of that would be how many residents were impacted and what were the repercussions of whatever it is we're inspecting.

I'm noting that we're running to the end of the time, so before I leave, I want to provide what I think are some great stats about what we've found and the number of inspections that we've conducted throughout the program. In 2015 alone, we conducted 2,459 inspections. Those included 800 complaint inspections and about 644 critical incidents, and there were about 360 follow-up inspections.

There is also a numbers story behind those numbers, because you can appreciate, with the volume of inspection that we do, that prioritization for inspections happens on a daily basis. It's not uncommon for us to roll a number of what we would call "intakes" into those inspection numbers, so with each one of those 2,459 inspections, we conducted about 5,300 intakes.

The good news is that with two years of resident quality inspections under our belt, we can also see some improvements in home performances themselves. In our previous year, in 2015, there was a total of 12 homes with no written notifications or any orders during the resident quality inspection cycle—

The Chair (Ms. Cheri DiNovo): I'm afraid, Assistant Deputy Minister, that your time is up. Thank you.

We now move to the official opposition. Mr. Yurek.

Mr. Jeff Yurek: I just want to follow up from the third party's question on take-home cancer drugs. It's $300 million that you figure it would cost for oral chemo

drugs to come home. Is there a plan to implement this soon, or are we waiting till we have pharmacare across the country to get to that point?

Hon. Eric Hoskins: As was committed to in the budget, the government has indicated that I will shortly be releasing a discussion paper specific to the various drug programs that the province administers—there are six different programs; you're familiar with Trillium, for example, and others—to really begin that conversation with Ontarians with regard to issues like the ones you've raised in terms of accessibility, the breadth of drugs that are and might be made available, issues of access, asking the question about consistency between the different programs, I think, like we did with Healthy Smiles, where we had six different programs benefiting children with regard to dental care and we merged them into one; asking the question of whether Ontarians would be better served if we looked at the delivery of the programs in a different way.

That discussion paper will provide us with the opportunity, including addressing, or at least inviting, the discussion on pharmacare on well—that discussion paper will provide the government and Ontarians, really, with the opportunity, over the course of a number of months, to have that fulsome discussion to address or at least to examine issues of sustainability, and to look at the progress made through the pan-Canadian Pharmaceutical Alliance, which Ontario holds office for.

I would suggest that that discussion paper, which should be released shortly, will provide the opportunity for the discussion, I think, that you've alluded to, with regard to that particular class of drugs.

Mr. Jeff Yurek: That starts the discussion, but I think I recall that in the budget, it was in 2019 that you would actually make any changes to the program. So for take-home cancer drugs, we'll have to wait till at least 2019—or do we have something in to get this moving a little quicker?

Hon. Eric Hoskins: Well, as we're making decisions with regard to medications and drugs week by week, it is a dynamic process. With regard to the inclusion of new drugs—the two hepatitis drugs for hep C, for example, which are close to, if not virtually, a cure, and the decision that was taken nationally that Ontario has subsequently adopted to bring those two drugs, which cost the government last year, I believe, approximately $300 million—the discussion paper and the timeline to look at a transformed drug delivery program through the government, which was referenced in the budget, obviously does not preclude other refinements and changes that might be made in the interim period.

Mr. Jeff Yurek: With regard to the methadone program—the drug version of it, not the drug testing or counselling that should go along with it—how much was spent or paid for through pharmacies and clinics for the methadone program last year? And is there an upward trend going on in Ontario?

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Hon. Eric Hoskins: I don't know if anybody behind us will have access to that information. That's something I can look at with the ministry, both with regard to the absolute figure and the trend.

Mr. Jeff Yurek: Okay. Has the ministry undertaken any reviews of the methadone program, or are you going to tie that in with the white paper coming forward?

Hon. Eric Hoskins: Last fall, I personally asked for a review of that aspect of the treatment and supports that we provide to those who are addicted or dependent on opioids, and specifically the methadone component of that. I did that on the basis that I believe there are significant measures that we can and should take in the province that will better reflect emerging best practices.

When I look to British Columbia, for example, the Vancouver Coastal Health authority has successfully transformed the nature of the support they provide, even moving beyond methadone in the first instance. I strongly believe we have opportunity in this province to serve the roughly 40,000 Ontarians who are receiving support through methadone treatment. I think that we can do better, so I have formed a task force specifically to address this issue in the context of the broader issue of opioid abuse itself.

Mr. Jeff Yurek: I would agree with you. I don't think you're getting your value for your money with regard to the methadone program in the province, with regard to the amount of money I would assume is spent on the pharmacy side of things. You'll get me those numbers, though?

Hon. Eric Hoskins: I certainly will look into that with my ministry.

Mr. Jeff Yurek: Okay. Talking about page 131—I'm just skipping over to the dental program in the public health section. Is the low-income dental program investment including Healthy Smiles, or is that what's coming over from the reallocation from ministry?

Hon. Eric Hoskins: Yes.

Mr. Jeff Yurek: It was an "or." Yes to both? It was an either/or.

Hon. Eric Hoskins: Oh, it was an either/or? The Healthy Smiles and low-income dental are, yes, one and the same.

Mr. Jeff Yurek: Okay, so it's coming over here. What were the cost savings? Did you have any by combining the six programs together that you mentioned earlier?

Hon. Eric Hoskins: We've certainly streamlined and improved the administration of the program, which, to be frank, was quite a burden for the dental providers themselves, the dental professionals. We may have the actual figures, but I want to point out that as a result of the transformation of the program, we've been able to enrol, in terms of eligibility, an estimated 70,000 more children across the province to the benefit.

Dr. Bob Bell: There are no savings, Minister.

Hon. Eric Hoskins: The deputy is just pointing out that in fact there are no savings because the savings we are accruing through efficiencies are being reinvested. If anything, if I look at calendar years 2013, 2014 and 2015, on a calendar-year basis—because a significant portion

of this is administered through public health, which functions on a calendar-year basis—$29.9 million in 2013 increases to $34 million in the most recent calendar year of 2015.

Mr. Jeff Yurek: Have you been looking to review the payment schedule for dentists with regard to Healthy Smiles? That's something I'm hearing quite a bit, that more could be done if the payments were closer to what they charge in reality.

Hon. Eric Hoskins: I've certainly had a number of conversations with individual dentists, as well as the ODA. In fact, it was at my initiative that I created a table within the ministry to work with dentists, including the ODA, to explore a variety of issues—not limited to the remuneration related to the Healthy Smiles program—to look at other issues of not just concern but of opportunity for dentists that they've been instrumental in pointing out to us.

The first meeting was several weeks ago that I attended. I am confident that it is going to prove beneficial to our intent of being able to further strengthen an important program.

Mr. Jeff Yurek: Also on page 131, you have $17 million allotted for the shingles vaccine. When will that program commence this year?

Hon. Eric Hoskins: It is anticipated that that program should be available beginning this fall, where eligible individuals will be able to obtain the shingles vaccine free of charge.

Mr. Jeff Yurek: And will that also incorporate the expanded scope of practice for pharmacists for travel vaccines to start this fall as well? Just say yes.

Hon. Eric Hoskins: Yes—roughly, yes. We've been working exceptionally hard with our pharmacist colleagues and those who represent them and made—again, there's a table format that was set up involving them to ensure that we had the right scope and breadth of vaccines, where we anticipate in the next number of months being able to actualize that. In fact, I believe that because there's a requirement now for a regulatory change through the College of Pharmacists, that that is the work that the college is now undertaking to be able to take the recommendations, which the government has then supported, and actually provide the regulatory environment for that to take place. But I anticipate that certainly by, if not late summer, early fall.

Mr. Jeff Yurek: Marshall's pretty effective at that job at the college. He'd probably be ready for prescribing minor ailments as well, if you want to take care of that as well.

Hon. Eric Hoskins: Well, yes, and I haven't been silent on that as well. I'm a big fan of expanding the scope of practice. The member for Ottawa South as well, my parliamentary assistant, has been doing considerable work with regard to scope of practice with the various health care professionals and those that represent them. Being a health care professional myself, I understand the importance of enabling health professionals to function and to work to the maximum of their scope.

Mr. Jeff Yurek: Okay. I'm just skipping over to Panorama. We learned that it cost more than double the $79 million to create, and now, on page 177, you're noticing an increase of another $1.2 million into Panorama. What do we expect to achieve with an additional expenditure on a program that's already double the cost?

M^me^ France Gélinas: Can you repeat the page?

Mr. Jeff Yurek: Page 177, please.

Dr. Bob Bell: I have the answer to that.

Hon. Eric Hoskins: Do you have the answer to that? Thank you.

Dr. Bob Bell: We would disagree that it was delivered for twice the cost. It was delivered on time and on budget. The $1.258-million investment in Panorama relates to the operational cost to the program now that it's fully operational.

Mr. Jeff Yurek: The Auditor General, who pointed out the additional cost, was off?

Dr. Bob Bell: Yes. This is operational rather than the implementation of the program.

Hon. Eric Hoskins: Because where we are currently with Panorama, all 36 public health units are operational using it now. There are more than six million client records contained within it and 90 million immunization records as well. So we've successfully built Panorama. It's now moved into that operational phase that the deputy has referenced.

Mr. Jeff Yurek: And when will that be able to actually communicate with eHealth and doctors' offices? I'm hearing that it's hit and miss wherever you are.

Hon. Eric Hoskins: Panorama was created to enable that rapid access by our public health units to this data. We released, I believe late in the fall, Immunization 2020, which is our plan for further strengthening the province's immunization program on a go-forward basis in the next several years. It was critically important to me, as a health care provider, and, having had experience in this as well, an important aspect and, quite frankly, something for families across the province—being a parent who has had to search for a yellow vaccine card, and try to remember which drawer it was in and make sure it's up to date—is to be able to make it easier for our health care providers—nurse practitioners and family doctors, for example—to be able to provide that information electronically into the public health system and make that available as well to clients, to individuals and families across the province so that they have ready access.

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Also, given that we have legislation in this province with regard to mandatory vaccines for children of school age, I believe it will enhance and strengthen that program so it's better for all partners: the family physician and nurse practitioner, the families involved, as well as the public health officials.

Mr. Jeff Yurek: So do you foresee, when the vaccination bill you have before the House is passed, that doctors will have to—that eHealth will be working with

Panorama at that time, or are they going to have to manually submit the reports to the health units?

Dr. Bob Bell: Currently, Panorama is accessible in read-only format through the cSWO-connected backbone in southwestern Ontario. We expect that will roll out to all 21 hospitals using cSWO over the next series of months, and subsequently through the connecting GTA backbone as well. That's in read-only format, allowing physicians working in hospitals to see the patients' immunization records.

Mr. Jeff Yurek: But the bill is going to mandate that the doctors now forward it. How is that going to occur if eHealth and—

Hon. Eric Hoskins: We're working with our health care providers. Obviously, it's subject to the legislation being approved by the Legislature. But we will be and are consulting with them. We'll work with our health care providers to determine what particular methodology is the best, that will work best for them, as well as that will reflect the advances that we've seen in eHealth and electronic health records and that also is appropriate with regard to our public health officials and the information that they require.

For me, this was a priority that was identified as an area where technology could really benefit all parties involved, in ensuring the validity as well as the timely availability of vaccine records, particularly, in the first instance, those that are focused on the mandatory vaccines required for school entry and remaining within school.

Dr. Bob Bell: As the program starts to roll out, physicians will communicate with public health units in the same way that they currently report reportable infectious diseases: currently a variety of means available to them that will be used to report vaccinations to be recorded in the Panorama system.

Mr. Jeff Yurek: Okay. On page 131—sorry, I'm jumping around here.

The Chair (Ms. Cheri DiNovo): Mr. Yurek, you have just over two minutes left.

Mr. Jeff Yurek: Thanks, Chair. Public health units: We're seeing an increased investment of $4 million. Currently, there are 28 health units who have frozen budgets. So is this $4 million going just to the remaining eight health units? That's part A of the question. Part B is, how long are these budgets going to be frozen for the remaining 28 health units?

Hon. Eric Hoskins: Do you want to jump in?

Ms. Roselle Martino: I'm Roselle Martino. I'm the assistant deputy minister for the population and public health division.

Mr. Yurek, we provide funding for health units for mandatory programs, but we also fund health units on top of that. The $4-million growth was the additional funding for programs and services for public health units on top of the mandatory programs, which is the health units that you mentioned didn't receive funding for that particular piece.

Mr. Jeff Yurek: So the $4 million is for all health units?

Ms. Roselle Martino: Yes. A number of health units submit—we fund a lot of programs 100%, and they also submit requests for one-time funding for a number of programs, depending on local priorities. That's what that funds for all 36 health units across—

Mr. Jeff Yurek: So how long is the funding freeze? Is it going to continue into next year as well? Or won't we know that yet?

Hon. Eric Hoskins: There's no funding freeze. Over a number of years, through a consultation process that was exceptionally inclusive, including our public health units and those that work within them, a new funding formula was agreed upon that has the support, for example, of ALPHA, the Association of Local Public Health Agencies.

As a result of that new funding formula, there were changes anticipated in the allocation of funds. For example, the formula improved because it was focused more on demographics, expressed and identified need, socio-economic factors, and growth factors within public health jurisdictions, as well. The administration of the formula might have resulted in a decrease in funding to certain public health units based on the agreed-upon formula that's now been implemented. However, as minister—

The Chair (Ms. Cheri DiNovo): I'm afraid with that, Minister, the time is up. Thank you, Mr. Yurek.

There being only a few minutes left, this committee stands adjourned until tomorrow at 3:45.

The committee adjourned at 1756.

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