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# Official Report of Debates (Hansard)

E-4

## Standing Committee on Estimates

Ministry of Health and Long-Term Care

1st Session
42nd Parliament

Wednesday 5 June 2019

Chair: Peter Tabuns
Clerk: Timothy Bryan

# Journal des débats (Hansard)

E-4

## Comité permanent des budgets des dépenses

Ministère de la Santé et des Soins de longue durée

1re session
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Mercredi 5 juin 2019

Président : Peter Tabuns
Greffier : Timothy Bryan

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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

# STANDING COMMITTEE ON ESTIMATES

# COMITÉ PERMANENT DES BUDGETS DES DÉPENSES

Wednesday 5 June 2019

Mercredi 5 juin 2019

*The committee met at 1558 in room 151.*

## MINISTRY OF HEALTH AND LONG-TERM CARE

**The Chair (Mr. Peter Tabuns):** Good afternoon, everyone. We're going to resume consideration of vote 1401 of the estimates of the Ministry of Health and Long-Term Care. There is a total of five hours and 10 minutes remaining.

Before we resume consideration of the estimates, if there are any inquiries from the previous meeting that the minister has responses to—and I know the time has been short—perhaps the information can be distributed by the Clerk.

**Hon. Christine Elliott:** Yes, thank you, Chair. I do have some answers to the questions that Ms. Gélinas asked yesterday.

**The Chair (Mr. Peter Tabuns):** Thank you so much, Minister. I appreciate it.

When the committee last adjourned, the official opposition had three minutes and 45 seconds remaining in the rotation; Clerks are very precise.

I turn it over to the official opposition. Ms. Karpoche.

**Ms. Bhutila Karpoche:** Good afternoon, Minister and team. Yesterday, we asked the government to provide calculations that you've used to estimate the savings from changes to OHIP+, the health care system restructuring, public health, land ambulance services, and other services cost-shared with municipalities.

Can the government also please provide a report that details these calculations for the committee, and can the committee also include in this report the costs that have incurred and are estimated to incur to make these changes?

**Ms. Helen Angus:** We can look into that.

**Ms. Bhutila Karpoche:** Okay. I would like to have those numbers tabled to the committee, if possible.

**Ms. Helen Angus:** We'll look to see what numbers we have and what we can produce. Obviously, this is a—

*Interjection.*

**Ms. Helen Angus:** Sorry, it's Helen Angus. I'm the deputy minister. Nice to meet you.

Some of the costs, we're still working on, with Ontario Health as an example, so they may not be finalized. But we'll look into what we do have.

**Ms. Bhutila Karpoche:** Okay. Thank you very much.

My next set of questions will focus on mental health and addictions. The budget shows spending of $174 million in mental health and addictions for 2019-20; however, this is a federal investment, as we know. Can the government please provide details for when they plan to start spending the $1.9 billion that has already been committed to mental health and addictions?

**Hon. Christine Elliott:** It is a historic commitment, as you know, a $3.8 billion total to be invested in mental health and addictions over the next 10 years; $1.9 billion of provincial funding and $1.9 billion of federal funding. These are monies that I will have to ask for assistance from the CAO with respect to the actual calculations. I believe that he will be able to explain to you how that money comes forward in each year.

**Ms. Bhutila Karpoche:** No, I'm looking for when we will start spending the provincial portion, the $1.9 billion.

**Hon. Christine Elliott:** I believe some of that is being spent already, but I'll ask for—

**Ms. Bhutila Karpoche:** Is it part of the $174 million?

**Hon. Christine Elliott:** Yes. Perhaps you could explain in greater detail?

**Mr. Peter Kaftarian:** Yes.

**The Chair (Mr. Peter Tabuns):** Could you introduce yourself?

**Mr. Peter Kaftarian:** Sure. Hi. Peter Kaftarian, chief administrative officer at the Ministry of Health and Long-Term Care.

Although there is a $3.8 billion, 10-year commitment, the $174 million that is flowing this year would be considered money being flowed by the province. There is a detailed federal-provincial agreement that's in place. There's a commitment for the province and the federal to match the funds over a 10-year period.

**Ms. Bhutila Karpoche:** I understand that. What I'm trying to seek is clarification: How much of the $174 million is federal money versus provincial?

**Mr. Peter Kaftarian:** The details of the breakdown of the federal and provincial share is something we can take back to look into and provide to the committee.

**Ms. Bhutila Karpoche:** Okay, because as I understand it, from what I've seen, the $174 million is all federal money, so I'd like to know when the province would start spending the $1.9 billion that they've committed.

**Ms. Helen Angus:** I believe if you look at the budget next year, the investments in mental health do start to increase. I don't know the exact portion of federal and

provincial, but the investment starts to ramp up next year. Part of that was related to the strategy of standing up Ontario Health. Because we are, obviously, creating a centre of excellence, and we want to make sure that we're making investments in the kinds of services that are really going to make the biggest difference for patients. We've had organized programs of work and organized clinical leadership, performance measurement and performance management in the cancer system, not so much in the mental health system. So we also wanted to make sure that we had the centre of excellence and the assets of Ontario Health so that we could really maximize the value of the investments in the coming nine years—

**The Chair (Mr. Peter Tabuns):** I'm sorry to say that you're out of time. Hold that thought.

To the government: Mr. Lecce.

**Mr. Stephen Lecce:** I just want to express my gratitude to the officials for participating today and to the minister.

My question is slightly tangential from mental health, Chair, but I will say, if I may, my expression of gratitude to the minister when you announced a $633-million investment with the Premier of Ontario to build two new CAMH facilities, which are critical to supporting people in the city of Toronto and across the region, adding 200 new beds. I know that will be well embraced by all members, I would submit, of this chamber. I know Southlake—which is a hospital near and dear to your heart, Minister, and to mine, given my riding includes King township—received additional beds to support those most vulnerable in mental health; again, another realization that the funding is flowing to the communities that need it most.

I did want to ask about procurement, because as we've seen across the ministry and since the government was elected, I suppose, a year ago, there's been a real focus, Minister—and to the officials—on finding savings and efficiencies through centralized procurement, which would be a common-sense measure in many provinces, certainly in the private sector, and in areas of health delivery that are looking to do more with less. Obviously, I appreciate that the integrated health sector supply chain is attempting to build on the successful models that exist both in this country and abroad. What we've seen, and this is the same as the case in other ministries—infrastructure, among others, where I have served those ministers—is that there are many dollars to be saved and realized through that approach.

I guess I would like to get a better understanding about the work that is being done on the supply chain initiative, and also to contextualize why it is important to improve the supply chain management plan, given the savings that can be realized without—and I want to stress this—without any impact at all to front-line service. In fact, one may submit that by doing this initiative, you enhance the service delivery of government. Perhaps you can corroborate that and provide perspective.

**Hon. Christine Elliott:** Thank you very much for the question. You're absolutely right: Supply chain is a critical component of a high-performing health care system. Our current health care supply chain model right now is a fragmented landscape. That means that many providers may be paying vastly different prices for the same or similar products and on administrative overhead. So the lack of integration and coordination impedes high-quality care for many patients and families and does not respect our health care dollars, and we know that we need to get the value out of every dollar that is invested in health care right now.

I am going to ask the deputy minister, in a moment, to please provide additional information on how the current system works and how health care sector supply chain transformation will result in savings through integration, better spend management, price harmonization, modern business practices and data analytics.

Deputy, please, over to you.

**Ms. Helen Angus:** Thank you, Minister. I've spent 30 years of my career in health care. Certainly, supply chain is probably not the first thing that comes to mind, nor has it been a focus of many of us in the sector, but now that we understand the supply chain and the opportunity that we have to make improvements, I realize how important it is as a critical component of a high-performing health care system. As the minister mentioned, it's a model right now in Ontario that's pretty fragmented.

If you look at how health care providers actually buy goods and services in the province, they do it through a whole bunch of different channels. That might include shared service organizations, national purchasing organizations. They may have their own internal procurement teams. As government—we're actually a purchaser as well; we have a government pharmacy, for example, that has a whole variety of goods and purchases—we might buy those through vendors-of-record relationships.

We have seven shared service organizations in the province, one national group purchasing organization and one hybrid organization that serves Ontario's hospitals. It's interesting, as we start to have the conversation about purchasing and about getting some more economies in how we buy products and services, we can already see some of the group purchasing organizations coming together. Mel will probably expand on that, but they obviously see the value in consolidation. In anticipation of the work that we want to do with the sector, they're already starting to move to figure out how they can offer us more value. We know that they can better coordinate with each other.

We're also not tracking products from the manufacturer to the patient, making it harder to track patient outcomes. I don't know—for those of you who have family or relatives who have had home care, it's not uncommon that you would actually see, as is the case in my own mother's house, a box of supplies that are left there after her home care visits have achieved the required outcome.

I think there's a whole lot that we can do in this space. There's another angle to this as well, because vendors, especially Ontario small businesses, also struggle to participate in Ontario's supply chain. We hear a lot about small, innovative companies that actually have more success in selling their products south of the border than

they do into the Ontario health care system. I think that's a challenge for us, because certainly there are administrative burdens that we can probably reduce in order to make their participation and their innovation—bring those benefits to Ontario health care patients and to providers.

So, Mel, you've spent a lot of time on this in the last few months. Maybe I'll ask you to dive a little bit deeper into the things that we're doing.

**Ms. Melanie Fraser:** Sure. I'd be happy to do that. I'm Melanie Fraser, associate deputy minister with the Ministry of Health.

Yesterday, we talked a lot about creating a sustainable health care system. I think the theme that you heard from us repeatedly was around integration. We talked a little bit about our Ontario health teams and really how this becomes our opportunity to integrate the sector and providers around patients and how that will contribute to the sustainability. We talked about Ontario Health, the single health agency that would help us provide an integrated and central point of accountability and oversight for the health care system, contributing to our ability to sustain and grow the services that people need. We also talked about digital tools and how technology and integrating technology into the patient's care journey will also produce better health care and better services and, again, more sustainable services as we go forward.

**1610**

Then we layer on supply chain, and it is just another opportunity to use integration as a tool to enhance the sustainability of the system.

As Helen said, when you think about the health sector or health care, supply chain isn't the immediate piece that would jump to mind, but it's a very important component of a high-performing health system and really does help us make the most out of every investment that we have into the system today, and every future investment that will come.

There have been lots of studies and there's lots of evidence that we're going to be building upon. Within Ontario, the health sector alone probably accounts for $12 billion in spend that could be captured by a modern supply chain, so that's between 15% and 20% of the overall health care spend. So, 70% is probably related to wages and payroll. This is another key component, and a sizable component, that we do need to look after.

We've looked across a number of jurisdictions, and what we found is, where they've transformed their supply chain—to your point—they've actually achieved better patient outcomes and savings through integration, through better spend management, through price harmonization and modern business processes and, of course, using data and patterns to be able to help with purchasing.

We have a couple of great examples in Canada. In Alberta, they were able to save over $261 million after moving to a modern, data-driven supply chain. It's good evidence that this is a model that will work in Canada. In British Columbia as well, they're projecting almost half a billion dollars in savings on a $2-billion addressable spend.

We're dealing with a $12-billion addressable spend here in Ontario, so we really feel that this is quite a real opportunity to drive not only savings but modernization.

We're also learning from partners internationally. The National Health Service in England has also done work on this, to look at adopting standards for everything from tracking products—their location, how they contribute to patient outcomes. As they are expanding there and scaling out their supply chain modernizations, they're projecting that they're going to be saving about $50 million a month—real savings.

Again, this is about, if anything, improvements to patient outcomes, not any deficiencies in services.

We're going to learn a lot from those examples. We certainly recognize that, in Ontario, there is some fragmentation. We have some great areas of excellence that—the deputy mentioned our shared services organizations. But we recognize that there is room for improvement, because we are procuring through multiple channels. Most sectors are procuring separately from each other. So if we think about integrating around the patient, having separate supply chains and multiple supply chains in each sector in the health care system is just not an efficient or effective way to drive the system.

As we mentioned, we have seven shared services organizations. They provide a range of services to hospitals. What a shared services organization is—we call them SSOs; we have an acronym for everything in health. They're not-for-profits and they are owned and funded by hospital members. The hospital members are actually customers of these SSOs, and they use them to operate their supply chain.

We also have something called a group purchasing organization, or a GPO. They're a little bit different. What they do is allow members to pool their purchasing power, to be able to benefit from volume pricing for goods and services.

But again, you can see from this model that they're just capturing small components of the supply chain and not actually taking a provincial approach to the supply chain or leveraging a value-based supply chain. I'll give you some examples of that, in a minute, that are quite real and quite compelling.

When we're talking about the health sector supply chain, we're talking about everything: strategic sourcing, contract management, transactional purchasing and ordering, logistics and inventory management. It's warehousing; it's vendor performance management; it's just-in-time cart management; it's accounts payable. Really running this as a sophisticated, modern, digital and data-driven business is our goal.

What we found is that when our organizations don't collaborate on procurement and don't really fully gather the supply chain together, they're not realizing the full potential benefit savings and, I think, some of the mid- to longer-term outcomes that we've been able to seize. So, lots of room for improvement. But let me give you a couple of really good examples, because I like talking about them and they really connect to our broader agenda.

One is wound care. I think what I came to learn when I came in to the ministry is how critical wound care is not only for the health and outcomes of a significant number of our population, but also its impact on hallway health care and how wounds that are inappropriately treated and don't follow standardized care pathways can lead to readmittance to hospital and recurring visits to hallways. When you look at the volume of patients that receive home care and are treated for wounds, we're talking about almost 700,000 patients a year getting some form of home care. There are 100,000 visits a day; a good percentage of those would be treated for wounds.

Coming to the ministry, I started getting letters—and I think you were talking about some of those—from patients who were saying, "I have all these supplies in my living room and they just kind of show up. I can't return them, because they've either expired or for safety reasons they can't be given back. So what do I do with them?" And they ended up being donated. Sometimes that's 10 boxes of supplies, whether that's bandages and the works, the kit for tending wounds. When you think about that times the number of people who are getting home care and the frequency of that home care, clearly there's an opportunity here to do more.

We're increasing home care hours by, I think, 1.8 million home care hours this year, another half a million nursing hours. This is an area that's growing, so the more that we can find savings here, the more that we can (1) ensure good outcomes, but (2) reinvest those monies to support the growing populations. So that's an interesting example.

I think another very compelling example of what we call a value-based supply chain manoeuvre relates to some experience that we have here in Ontario on implantable cardiac devices, or ICDs—defibrillators. These are the things that get implanted surgically. We launched our first province-wide procurement. It was a really amazing example of bringing together providers.

We worked with the 12 ICD centres in the province and collaborated with them to look at an opportunity to try to capture the provincial spend on this—and not only to capture the provincial spend, but to take the best advice from those leaders in cardiology in terms of what devices would be best for their patients and for their outcomes. We also invited vendors to come and bring us their innovations and their technologies and show us what could exist for patients in Ontario. I think the most amazing thing is we put patients at the centre of it and said, "What do patients actually want?"

The result of that procurement was that patients told us they don't care about bells and whistles. They don't care if their device sends something to their smart watch or to remote monitoring. They don't want surgery again; they want this device to last a long time and to be really stable. The best outcome for them is a long-lasting device that functions and keeps them from having repeat surgeries. Our vendors worked with us to meet those outcomes, and the providers provided input into the quality of devices that we would procure.

In the end, through this procurement, we were able to save, I think, $100 million over five years, so significant savings. But, I think, most importantly, patients were very, very satisfied with the outcome of this. When you look at the cost avoidance from multiple surgeries or multiple procedures, we took the patient journey into consideration. So it just wasn't about what was the best device at the right price, etc.; it was more about how do we take their whole journey into consideration and what are some of those medium- and long-term implications that might not be captured in a fragmented supply chain or a local procurement.

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We've had this success, and I think we learned a lot from it. It wasn't easy. It's not ever easy to get different groups together, but it was a huge success, and this is what we are looking at scaling as we move across the province.

I love to tell that story. I wasn't here. I'm not responsible for it at all, but I think there are people probably back there who should be patting themselves on the back because they worked really hard to do that.

**Mr. Stephen Lecce:** Ms. Fraser?

**Ms. Melanie Fraser:** Yes?

**Mr. Stephen Lecce:** Permit me to ask a follow-up. You had mentioned, ma'am, that there was a $500-million, a half-a-billion-dollar savings in British Columbia. Remind me what year that took place, if you recall. I know I'm putting you on the spot, but do you recall in what fiscal year that would have been realized?

**Ms. Melanie Fraser:** They're projecting a half a billion dollars on a $2-billion addressable spend. I don't know. I couldn't confirm for you if that's a multi-year figure. When we think about supply chain, because of the pace of procurements and the pace of how contracts are actually activated and how these things roll out, we tend to think in longer-term cycles.

**Mr. Stephen Lecce:** But is it the current government?

**Ms. Helen Angus:** Yes.

**Ms. Melanie Fraser:** Yes, I believe so.

**Mr. Stephen Lecce:** You believe it to be.

**Ms. Melanie Fraser:** Yes.

**Ms. Helen Angus:** What I think is interesting about this is, it's the Provincial Health Services Authority. That was one of the models that we looked at when we gave advice to the government on what the structure and accountability of Ontario Health should be. So the Provincial Health Services Authority in British Columbia was one of the areas that we looked at that had kind of consolidated some of the provincial oversight, including procurement, into a provincial authority, and the fact that they were able to get these kinds of savings, as well as clinical improvements in a number of program areas, was very attractive to us. It's not the only model. We looked around the world, but certainly they have given us comfort and guidance on the fact that the direction for Ontario Health is really the one that's going to deliver results for us, including in procurement.

**Mr. Stephen Lecce:** I ask that question, ma'am, because I just note the divergent political and ideological

convictions of that government. They're New Democrats, and yet they initiated that, if I understand that to be correct, and I think it speaks to a common conviction that governments should be challenging assumptions on how we spend money and how we better procure services. So it's good to see that we're looking at all models, and I would challenge all members to embrace that spirit.

Ma'am, you spoke about small businesses and leveraging Ontario's small businesses. I don't harbour protectionist sentiments personally, but could you just expand on how you want to do that and create jobs and support—

**The Chair (Mr. Peter Tabuns):** Mr. Lecce, I'm sorry that you're out of time.

**Mr. Stephen Lecce:** Oh, pardon me.

**The Chair (Mr. Peter Tabuns):** As much as you were having a good time—sorry. Back to the opposition. Ms. Karpoche.

**Ms. Bhutila Karpoche:** Going back to my questions on mental health and addictions, we learned recently that Ontario's Financial Accountability Office reported that $69 million was cut this year from child and mental health programs, compared to the 2018-19 budget. Can the government please confirm if this is accurate? And if it is accurate, if you could please provide an explanation of why there is a cut in funding for children and youth mental health and addictions, given that we have over 12,000 children on wait-lists waiting 18 months for the services that they need, and recognizing the state of mental health crisis that we're in and the fact that we actually need more services and more funding.

**Hon. Christine Elliott:** Well, I can certainly confirm that it was not actually a reduction in child and youth mental health. It was, really, largely a result of how the 2018 budget figures were represented.

Through the 2018 budget, a total of $68.6 million was announced for child and youth mental health and was allocated to the Ministry of Children, Community and Social Services, which is formerly the Ministry of Children and Youth Services. Of that funding, only $18.6 million was initially committed to the sector in the early part of 2018-19. It was actually in May 2018. Since then, our government has implemented a $10-million investment in late 2018-19 to address service gaps identified through community planning. So funding that was not fully implemented has been taken out of the child and youth mental health line and is being considered as part of the larger mental health and addictions strategy and supporting investments with our government committing $174 million for 2019-20 and $3.8 billion over 10 years. Through the strategy and investments, I realize this has gone in and out of several ministries and has gone from one line to the other, but it actually is an increase over time, not a decrease.

We are focused on improving services for Ontarians through better alignment and integration of mental health and addiction services across the lifespan, and stronger connections to the broader health care delivery system.

That's the reason for what looks to be a reduction. It is not; it is actually an increase.

**Ms. Bhutila Karpoche:** Okay. Thank you very much. Also, recently, the government announced that you'll be investing $30 million for child and youth mental health services and programs across Ontario, and $27 million to fund mental health supports in Ontario's education system. Can you please indicate if this is $30 million for children and youth mental health services with an additional $27 million going to supports in schools?

**Hon. Christine Elliott:** Child and youth mental health services received base funds of $406 million, with an additional $28.6-million investment in 2019, for a total of $434.6 million. The services in the schools would be—excuse me just a moment while I check this.

**Ms. Helen Angus:** They are separate pots of money. There's $30 million for child and youth community mental health services, as you mentioned, and then there's another $27 million to support children in the education system. Those are two distinct—

**Ms. Bhutila Karpoche:** Two different sources. Okay.

**Ms. Helen Angus:** Correct.

**Ms. Bhutila Karpoche:** For the schools, will the supports be flowing through the Ministry of Health or the Ministry of Education?

**Ms. Helen Angus:** I believe we actually have the accountability here now for adult and children's mental health. That was a change that was made last year. Whether we actually journal-entry that on the way to education, or we fund directly—I think we're not totally sure what the machinations are behind the scenes with our colleagues at Treasury Board. It's certainly showing up in our budget—

**Ms. Bhutila Karpoche:** The Ministry of Health?

**Ms. Helen Angus:** Yes.

**Ms. Bhutila Karpoche:** Okay. The $30 million that's allocated for child and youth mental health: How will that be allocated in terms of distribution? Will it be going through the mental health lead agencies?

**Hon. Christine Elliott:** There will be a variety of ways that that will be flowing. There will be some funds that will go through some of the agencies. Some of it will go to more counsellors in community agencies. There's a variety of ways that it will flow.

But I think I'll ask ADM Dicerni, if you don't mind providing further information on this particular issue. Thank you.

**The Chair (Mr. Peter Tabuns):** Please introduce yourself for Hansard. Thank you.

**Mr. Patrick Dicerni:** Hello, committee. My name is Patrick Dicerni. I'm the assistant deputy minister in the Ministry of Health and Long-Term Care, responsible for policy and strategy, and that includes mental health.

Further to what the deputy and the minister have said, those are two distinct pots of money. I'll have to come back with some more details with respect to the way the journalling would work, but those are funds that are flowing through the Ministry of Education into the school environment.

Picking up on the minister's last points, that funding—and I'm happy to provide the breakdown, but publicly

available being, we're investing funds in a core services framework for child and youth mental health, which does already exist, as well as, as the minister referenced, an across-the-board increase to children's mental health agencies that did roll out in May of last year.

**Ms. Bhutila Karpoche:** So what's the timeline for that, in terms of front-line agencies being able to access the funds?

**Mr. Patrick Dicerni:** Those funds, in terms of 2019-20 funds, are rolling out as we speak, through the normal course of disbursement to the agencies.

**Ms. Bhutila Karpoche:** It has already begun, the process?

**Mr. Patrick Dicerni:** Yes.

**Ms. Bhutila Karpoche:** Okay. Is this funding separate, or an addition to the federal announcement, or is it the same?

**Mr. Patrick Dicerni:** While the federal investment in home care and mental health originates at the federal level and flows through the provincial treasury, it is disbursed by the provincial government, not the federal government, into Ontario. There is, as mentioned, a total of 174 million incremental new dollars coming into the mental health system.

**Ms. Bhutila Karpoche:** Okay. What I understand, from what you're saying, is that the $30 million, the $27 million, all of this is federal money that is flowing through the province, not provincial dollars. Correct?

**Mr. Patrick Dicerni:** Over the 10-year period of time—

**Ms. Bhutila Karpoche:** For this year, I mean.

**Mr. Patrick Dicerni:** This year, the investment is $174 million. The minimum investment required in this area for the 2019-20 fiscal year is, as per our agreement with the federal government, $174 million.

**1630**

**Ms. Bhutila Karpoche:** So the province has matched the $174 million?

**Mr. Patrick Dicerni:** No, it's 174 million total incremental new dollars.

**Ms. Bhutila Karpoche:** Do you know how much of that is provincial money?

**Mr. Patrick Dicerni:** One might look at it as all provincial money as it is flowing from the provincial treasury to mental health agencies, hospitals and supportive housing agencies in the province.

**Ms. Bhutila Karpoche:** Okay. I'm still not clear, based on your response. But anyway, moving along, I'd like to—oh, I do have one more question on mental health and addictions. Obviously, the government has announced that you plan to create the Mental Health and Addictions Centre of Excellence. Has the government calculated how much that is expected to cost?

**Ms. Helen Angus:** Do you want me to jump in?

**Hon. Christine Elliott:** I'll just initially say it's not intended to be the creation of a whole new bureaucracy. What we're looking at is just an agency that is going to be able to compile this information and provide that infrastructure for the mental health and addictions strategy that we're working on. Some of the people are already there; we are not looking at creating a huge, large structure. We anticipate that the investments will be quite minimal, but I'll ask the deputy to provide further information.

**Ms. Helen Angus:** That's exactly right.

It's Helen Angus again. We have an experience where we used the assets of Cancer Care Ontario, for example, to set up the real network inside the walls of CCO at a fairly modest cost to expand, again, the measurement and performance management and capabilities of that organization to really make a measurable improvement in care for people with chronic kidney disease.

We expect to be able to use the same methods, some of the same data sources, some of the same people, with somewhat different clinical leaders, to actually help us with setting up the centre of excellence. There are pockets of capability across the province. You probably would know that there's a program—Patrick will remind me of the name—at the Centre for Addiction and Mental Health that has a provincial mandate. We just need to get them all rowing in the same direction and providing guidance and support for getting better patient outcomes for the mental health dollars that are going to be invested.

We think that there's quite a lot of capability in the mental health system. It just hasn't been harnessed in a way that really has us hopefully making leapfrog improvements for patients in terms of outcomes and patient experience. I'll go back to—you weren't here yesterday, but we talked about the quadruple aim being better patient experience, better provider experience, better health outcomes and better value for money.

**Ms. Bhutila Karpoche:** Yes, I do understand the purpose of the centre. I'm seeking clarification in terms of—obviously, there will be a cost associated with it, even though you do hope that it's not another massive bureaucracy that patients would have to navigate. So has that cost been calculated?

**Ms. Helen Angus:** We're working with Ontario Health to look at what assets they can leverage as they bring in the other agencies like CCO, like—

**Ms. Bhutila Karpoche:** When do you expect that you would have an idea of the cost?

**Ms. Helen Angus:** I think as we work with them on their first-year budget, we will have a sense about what funds they are going to purpose within their walls towards mental health.

**Hon. Christine Elliott:** But we do anticipate that it will be a minimal spend. I think that there are two research funds that are already operational: the one that the deputy minister mentioned at CAMH, and there's also one at the Children's Hospital of Eastern Ontario for child and youth mental health. We want to make sure that we can bring them in and work with them, not try and reinvent the wheel. They're already doing great work. We just want to pull it all together and make sure that it's going to be able to produce the outcomes that people are expecting.

One of the reasons that Cancer Care Ontario was brought into Ontario Health is it is, in many respects, a model for the management of what is, in some respects,

now a chronic disease. When we had the select committee in operation almost 10 years ago, I can say that Cancer Care Ontario was the model that we looked to as being the best for the creation of—then, we called it Mental Health and Addictions Ontario. It remains as a great model, and I think can also be used not just for mental health and addictions but also for other chronic disease management states, diabetes being a good example.

**Ms. Bhutila Karpoche:** Okay. Thank you very much.

I'd like to ask my next set of questions on the opioid crisis. The Ontario government signed the emergency treatment fund with the federal government to address the opioid crisis. By 2021, the Ontario government must match the $51 million of federal funding. Can the government please detail how much of that funding it has invested this year to address the opioid crisis?

**Ms. Helen Angus:** I'm going to look down at my CAO. We've actually been able to pull together from various parts of the ministry the funding that we provide to address the issue of opioid use in Ontario, because it does sit in various lines within the ministry, so it is distributed.

But maybe between Peter and Patrick, you can kind of give the MPP an overview.

**Mr. Patrick Dicerni:** I'd be happy to. Again, Patrick Dicerni, Ministry of Health and Long-Term Care.

As the deputy mentioned, the overall spend in terms of the opioid crisis and response is in the range of $121 million for the coming 2019-20 fiscal year. That represents a $38-million or so approximate increase over the spending last year. As the deputy mentioned, that is parked, or distributed, across a number of vote items in the ministry, the reason being, when we look at the multiple faces or texture of the opioid crisis in the province, there's work that's required on multiple levels with multiple sectors.

To name a few, there's a prescribing problem in the country, there's a prescribing problem in the province—and that is a series of, whether it be educational endeavours with our prescribing practitioners in terms of what is appropriate in terms of a post-acute episode, or pain management, or other techniques that can be used. This includes something called academic detailing, which would be an exercise with a primary care physician, for example, really going through, line by line, your prescribing practices to see where you could be doing a better job.

There are also some technological assets or assists that we can bring in in terms of requiring a prescriber or a practitioner to ask a series of probing questions of themselves before they issue prescribing. That's one basket of activities which will hopefully stem some of the generation of the problem to begin with.

**Ms. Bhutila Karpoche:** How much are you spending on that?

**Mr. Patrick Dicerni:** I'd be happy to take that back. I just don't have that level of detail at my fingertips right now.

**Ms. Bhutila Karpoche:** Okay.

**Mr. Patrick Dicerni:** With respect to addressing the crisis from a treatment perspective, the minister had spoken earlier already in front of the committee around some of the consumption treatment investments that have been made as well as, broadly speaking, harm reduction in the area of making sure that naloxone is available, and ready access to it, whether that be through pharmacies, through public health units and other locations. Those are available free of charge in pharmacies without demonstrating or showing an OHIP card, in an effort to make sure that there are no barriers to accessing that life-saving drug.

With respect to more treatment aspects, there's something called RAAM clinics, or rapid access addiction medicine clinics, which does provide a higher level of intervention and support for somebody who is perhaps ready to start a treatment journey due to an opioid use disorder. As I said, the minister touched on the new model around consumption treatment sites, the goal being providing a ready or more ready access for somebody to begin a treatment journey while continuing to use substances.

**Ms. Bhutila Karpoche:** So as I understand it, this is one of the very few items where the provincial government must match the federal funding for this year. So, if it's possible—I know you don't have the numbers now—I'd like to see how much of the province's money has been allocated in order to match that funding into the opioid crisis, and a detailed breakdown of that, if possible.

**Ms. Helen Angus:** I think we actually have some detail here.

**Mr. Peter Kaftarian:** Hi. Peter Kaftarian, chief administrative officer, Ministry of Health.

The funding hits several different votes within the book. It hits within, for example, ministry admin under the OHIP line 1405; drug programs, 1405-2 as well; population and public health. We can take it back and we can look into getting a summary.

**Ms. Bhutila Karpoche:** Okay. I just want to see the match, if that has happened or not.

**Ms. Helen Angus:** It was roughly $9 million in the first—

**Ms. Bhutila Karpoche:** Okay, sorry. Moving along, the government has yet to provide funding for the six remaining CTS sites that it committed to fund. When will the government release the funding for these sites?

**Hon. Christine Elliott:** As soon as the sites have been decided upon. They're still receiving applications, still reviewing the sites, making sure that we apply the same criteria to all of the sites that are applying: making sure that, first of all, there is a need in a geographic area; secondly, that the services can be provided, the wrap-around services that people need; once they make the decision to enter rehabilitation, that the services have to be available as well in the community; and that there's an ongoing community consultation. We are reviewing all of the sites that we've received applications from on that basis. We anticipate that the remaining six sites will be released in very short order. I can't give you an exact date, because we are still completing a review.

**1640**

**Ms. Bhutila Karpoche:** Okay, thank you. And can you tell us how the money for the six sites that have been

unfunded will be redistributed? Will some of that slippage go back into front-line overdose prevention services?

**Hon. Christine Elliott:** I believe there has been a total of $31 million—I'll have to check with Mr. Kaftarian on that amount—for the overall number of sites. We anticipate that the remaining six sites will be funded out of that remaining budget.

**Ms. Bhutila Karpoche:** Okay. And has the government completed a risk assessment that calculates the burden of the opioid crisis on the health care system, to do hospitalizations and other overdose services that are carried out through other services?

**Hon. Christine Elliott:** Well, we're certainly aware of the risk. That's one of the reasons why we have come forward with the bill through Minister Mulroney's office to join in the British Columbia national class action lawsuit, to try and seek damages for the additional health care costs incurred as a result of people becoming addicted to opioid medications.

There are a number of manufacturers that are involved in this. There is a lawsuit that has been started in the United States. We anticipate that it's going to trial this fall. There are some settlement negotiations that I understand are starting up very soon, so I hope that we will be able to move forward with this. That's going to be subject, of course, to debate in the Legislature, but I hope that we will be able to move forward with that, so that we can partake in those discussions, because we know that the costs are significant, in the hundreds of millions of dollars.

**Ms. Bhutila Karpoche:** Has the cost been calculated in terms of the impact on our health care system because of the opioid crisis?

**The Chair (Mr. Peter Tabuns):** One minute left.

**Hon. Christine Elliott:** We know that it's in the hundreds of millions of dollars. If you'll bear with me for just a moment, I will just speak with the deputy about that.

**Ms. Helen Angus:** In fact, I think we have been able to use some of our data to quantify the nature of the interactions with the health care system, although not necessarily costed in detail. But to be clear, it's significant.

We just looked back in 2017. Obviously you can't put a price on a life, but there certainly were 7,800 emergency department visits in 2017, and 2,155 hospitalizations. So we've got some of the building blocks. I'm not sure that we've costed it entirely, but that would be part of the work that we would want to do as we look to recoup hopefully some of the costs from the manufacturers.

**The Chair (Mr. Peter Tabuns):** And with that, I'm sorry to say that you're out of time.

We'll go back to the government. Ms. Triant—afilopoul—

**Ms. Effie J. Triantafilopoulos:** Thank you, Chair, and thank you for trying my name. That was a great effort.

*Laughter.*

**The Chair (Mr. Peter Tabuns):** I tried.

**Ms. Effie J. Triantafilopoulos:** Minister and ministry officials, thank you very much for being here today.

I'd like to move along and ask you some questions around the long-term-care redevelopment. As we all know, some hospitals in Ontario are continuing to struggle with occupancy challenges and very long wait-lists in emergency departments, and many patients receive care in "hallway health care," as we call it. We know that one big challenge is that many of these people in hospital beds would be more appropriately cared for in a long-term-care setting; however, the waiting lists for long-term care are also very long. This means that patients remain in hospitals longer than they really need to.

Minister, I'd like to ask you: You've made a number of announcements over the last few months about new long-term-care projects across the province. Can you please give us an overview of our plans to build new long-term-care homes, and also perhaps touch on how people, increasingly with complex care needs, are going to be cared for in this new long-term-care environment?

**Hon. Christine Elliott:** Yes. Thank you very much for the question. The issue of people waiting long periods of time for long-term-care beds in Ontario is quite distressing. There are over 30,000 people right now who are waiting for spaces, and that is difficult for them. They end up being in hospitals for a lot longer than they would like to be, and they want to go home, but if they can't go home, long-term-care is a more home-like setting for them.

We are in the midst right now of building a coordinated and connected public health care system that puts the people of Ontario at the centre of care. For seniors who need long-term care, we are committed to ensuring that their quality of life remains high and that space is available for them when and where they need it.

We are investing an additional $1.75 billion in Ontario's long-term-care sector that will support more beds, nursing and personal support care, and programs and support services for both residents and families. We have committed to creating 15,000 new long-term-care beds in the province in five years in order to help increase access to long-term care, reduce wait-lists, alleviate hospital capacity pressures and end hallway health care. To date, I'm very happy to say, almost 50% of the first 15,000 beds have been allocated.

In addition to our commitment to creating 15,000 new long-term-care beds, we have also committed to upgrading an additional 15,000 older long-term-care beds to modern design standards, which will allow the long-term-care sector to provide more appropriate care to those with complex health conditions. The ministry is going to actively engage with the long-term-care sector to support innovation in the delivery of long-term-care services and its supporting infrastructure. We will also continue to work with all of our partners to ensure proposed projects will serve the needs of their local geographic communities.

I am going to ask the deputy minister to please provide more information on how we are working to modernize long-term care and how creating new and upgraded long-term-care beds will help us end hallway health care.

**Ms. Helen Angus:** Absolutely. Thank you, Minister.

I think we all know that many people are in hospital because the appropriate care that they need, such as care in the community or in long-term care, is not available to

them. We look, on a regular basis, at both alternate levels of care—those are people who are in hospital who could actually be cared for better elsewhere. We know that that's a significant problem in Ontario hospitals—roughly about 16% of all hospital beds are used for ALC—so that's really a big part of the imperative to address the long-term-care needs of the province. And, of course, there are people in the community who are waiting for an appropriate placement into long-term care.

I'll talk a little bit about the money. There is $267 million this year in additional funding to support home and community care, and there's $27 billion in total over the next 10 years that will create over 3,000 new hospital beds. We're very seized with the need to increase the overall capacity in the system on the community side, in long-term care and in hospitals, and have them all work together seamlessly. Also—and we've just been talking about that—the $3.8 billion to support mental health and addictions services and housing supports will also help create the modern, efficient health care system that we're all aiming towards.

We know that people shouldn't be waiting in the hospital. The minister has talked about the 15,000 new long-term-care beds that are rolling out across the province over the next five years. The last time that long-term care beds were added in any significance to the sector was in 1998, so that's a long time since we've actually been building up this kind of capacity in communities.

We're working with partners to make it easier to leverage government-owned lands and enable new long-term-care home developments. I think that's quite an exciting sense of possibilities, because one of the barriers has been the acquisition of land for long-term care. We know that these beds will actually increase needed access, reduce wait-lists and support the government's commitment to end hallway health care.

There's also work—and I'll ask Brian to talk in a few minutes—to streamline our processes, because we want to get the beds built quickly and well, so that they are available as soon as possible. The minister talked about over 1,100 additional long-term-care beds; I would say that they're going to add capacity across the province, in both urban and rural environments. We're looking forward to reviewing and continuing to make those investments quickly, so that we can get on with the work and get people into the most appropriate setting that they need.

**1650**

Brian, why don't you introduce yourself, and they'll understand why you're in the best position to give the committee more details about the long-term-care redevelopment program.

**Mr. Brian Pollard:** Thank you, Minister. Thank you, Deputy Minister.

Good afternoon. My name is Brian Pollard. I'm the assistant deputy minister for the long-term-care homes division here within the Ministry of Health and Long-Term Care.

I'll just start off by giving you a sketch of the mandate for the long-term-care homes division. We are responsible for implementing the government's direction for the provincial long-term-care homes sector, which serves over 100,000 residents every year. The division accounts for about $6 million in spending, three quarters of which comes from government, and the other portion comes from copayment that residents pay. That helps to ensure that long-term-care residents have access to the high-quality, specialized care they need, as you heard the minister talk about.

Working with our partners across Ontario, the division is leading the design, development and implementation of legislation, regulation and policy related to long-term care. We provide program and sector oversight and administration, and administer long-term-care home licences. Just for fun, we also oversee the accountability and compliance of long-term-care homes as well as X-ray facilities.

While we recognize the ongoing dedication of health care workers across the province, we know that there are capacity constraints in our health care system, and I hear about them every day. The sector has told us that some things need to be done differently.

For the past 17 years, I have been proud to work with leaders in our health care system across Ontario, including the province's hospitals and long-term-care homes sector. Working with people across the sector and across the province has provided me with the opportunity to see first-hand the shifting challenges within the system.

It has also provided me with insight into the opportunities that we have to modernize long-term care. Some of those opportunities were highlighted with the Premier's Council on Improving Healthcare and Ending Hallway Medicine, led by Dr. Rueben Devlin, which released its first report in January 2019. The parliamentary assistant was there with me at those meetings. The report highlighted the fact that at least 1,000 people are regularly receiving health care in hospital hallways on a daily basis.

Access to a long-term-care bed can vary across our province. As our province's demographics shift, the number of people on the wait-list has increased. As of February 2019, 98% of our long-term-care beds were occupied, so we're running pretty much at full occupancy. As a result, more than 34,000 people in Ontario were on a wait-list for admission to a long-stay bed in a long-term-care home facility. The median wait time for long-term care was 161 days as of February 2019. This reality is straining our hospitals, home care and community services and preventing individuals from receiving the care they need where they need it. That's why the ministry is working to modernize long-term care and create new and upgraded long-term-care beds.

There are more than 78,000 long-term-care beds in the system in over 620 homes across the province. These homes are operated by for-profit, non-profit and municipal operators.

The sector employs over 52,000 dedicated staff, who provide interdisciplinary care to over 100,000 residents, as I mentioned before. These dedicated staff include on-call doctors, nurses, personal support workers and allied health professionals such as physiotherapists, dietitians and

programming staff. I'd underscore here that it's not only the care requirements that we're providing in long-term-care homes—but also keeping people active in their home. They are providing high-quality, resident-centred care to some of our province's most vulnerable and increasingly medically complex individuals.

Since 1998, the ministry has successfully built and upgraded thousands of long-term-care beds across the province, but as the deputy said, we haven't built many more since that time. As the minister mentioned today, the government is investing an additional $1.75 billion in Ontario's long-term-care sector to support more beds, nursing and personal support care, and programs and support services for residents and families.

At the same time, recognizing the diverse and changing needs of people across Ontario, the ministry is working with the long-term-care homes sector to establish new approaches and opportunities to develop and upgrade long-term-care beds across the province. Because of the ministry's ongoing partnerships, we're also working on ways to promote integration of long-term-care homes within the province's health care system; encourage innovation in the provision of care; reduce red tape; streamline government processes; and reduce the regulatory burden on the sector, while maintaining standards that ensure the safety and security of long-term-care residents are maintained.

As we work to modernize long-term care, we are creating 15,000 new long-term-care beds across the province in five years and upgrading an additional 15,000 older long-term-care beds to modern design standards. Today, the oldest beds in the province do not meet the standards in the 1972 Nursing Homes Act regulation, and many of the older homes do not have sprinklers, which must be installed in every long-term-care home by 2025.

By enabling operators to upgrade older homes in the province, the sector will be able to provide better quality care to the people of Ontario. It will enable long-term-care home operators to upgrade their existing homes, either by building a new home or renovating an existing home so that it complies with the province's current design standards and applicable legislation and regulations, such as the Long-Term Care Homes Act, the Fire Code and Building Code, and the Accessibility for Ontarians with Disabilities Act.

Currently, the main source of funding provided by the ministry for long-term-care projects is a 25-year construction funding subsidy. The subsidy is provided to eligible long-term-care home applicants that are approved to develop or upgrade long-term-care beds. It is provided once a project is complete if the applicant has met all requirements, successfully completed construction in accordance with their development agreement and received ministry approval to admit the first resident.

For organizations upgrading existing beds or developing new beds, the ministry also has a dedicated team of project managers who coordinate government decision-making and streamline government review and approval processes. This small team reviews hundreds of applications to identify those projects that will provide the right care in the right location for the people of Ontario, and they work on a daily basis with organizations across Ontario to help advance projects through the review of design plans, through the start of construction and opening up new and upgraded long-term-care beds.

Thus far, the ministry has allocated almost 50% of the first 15,000 new long-term-care beds across the province, as the minister has indicated. We have recently allocated an additional 1,157 long-term-care beds, which will add new capacity in rural and urban communities. For example, we have an allocation of 256 new long-term-care beds that will enable a new long-term-care home to be built in Markham. We have an allocation of 128 new long-term-care beds that will enable a new long-term-care home to be built in Sault Ste. Marie, and an allocation of 160 beds will enable a new home to be built in Orillia.

Additional allocations announced in the 2019 Ontario budget will both upgrade older beds in the province and increase the size of existing long-term-care homes. People in Athens, Owen Sound, Collingwood, Palmerston, Mount Forest, Tecumseh, Komoka and Midland will see new and renovated homes in their communities, while people in Scarborough, Welland, Strathroy and Milverton will have more spaces available in newer existing long-term-care homes, just to give you some examples.

As the division continues to work with the sector to create new and upgraded long-term-care capacity, we're also working to ensure long-term-care residents have access to the specialized care they require. We know that many of the ALC patients who are in hospital have specialized care needs, which is why it's critical that we pay attention to the service delivery model as well. That is why, as the demographics of Ontario's population changes and the needs of residents in long-term-care homes become more diverse and complex, we have prioritized long-term-care development projects that will help address ALC, crisis wait times, population growth and the needs of increasingly complex residents.

We've also taken account of the diverse needs of Ontarians across our province, including the needs of Indigenous people, francophones and cultural and linguistic communities. Today we're working on a plan to move quickly to allocate the remaining beds, so that the people of Ontario have access to the specialized care they need, when they need it. We continue to engage with the long-term-care sector and the people of Ontario to support innovation in the delivery of long-term care.

We are responding to the sector's call to address the challenges experienced by smaller homes, which are often located in rural and northern communities. For example, we are working towards reducing red tape, streamlining policies and increasing funding flexibilities to leverage existing investment into small homes to improve supports.

We are committed to ensuring that once a home is built or renovated, it will be able to provide a safe and secure environment a person can call home. Ontario long-term-care home inspections continue to be the most rigorous in Canada, and a majority of homes are considered to be in good standing with the requirements of the Long-Term

Care Homes Act. Today, when a home reports a critical incident to the ministry, the report is triaged and appropriate action is taken. The ministry also conducts inquiries and inspections based on complaints made by residents, family members, long-term-care home staff or members of the public.

To end hallway health care and increase access to long-term care, the ministry continues to work with our partners to ensure that Ontarians who need long-term care receive timely access to quality care best suited to their needs in environments that facilitate that care.

We are committed to modernizing our long-term-care system—that responds to the needs of front-line health care workers, residents and their families, and that has the capacity and care structures that better respond to the changing and diverse needs of the people of our province.

**The Chair (Mr. Peter Tabuns):** Ms. Triantafilopoulos.

**Ms. Effie J. Triantafilopoulos:** I wonder, Mr. Pollard, if you could also describe to us a little bit more around the human resources challenges, and the fact that in this sector, we're somewhat challenged in terms of the need to support long-term-care residents. I know that if we're going to go forward with building all of these new long-term-care beds, the human resources are going to be key in order to make that a success. Could you share with us your plans there?

**Mr. Brian Pollard:** Thank you, Parliamentary Assistant, for the question.

Health human resources supply is an absolute issue that we are continuing to look at. I would probably answer the question in two ways. One is to say that every effort is being made to retain staff in the system. We have, over the last little while, invested in initiatives such as a PSW education fund to make sure that PSWs, when they come into the workforce in long-term care, don't feel overwhelmed by the work that is in front of them, and to give them the necessary skills and coaching that is required. That's just an example.

Another example would be outfitting long-term-care homes with better technology, so that they have the ability to use staff more effectively and efficiently. As I said, that's just another example of things we're doing to retain staff in the system.

All homes are required to have a 24/7 RN at this point in time. There has been active work in the last little while to make sure that that standard and regulation can be met, by monitoring homes for compliance.

**The Chair (Mr. Peter Tabuns):** You have one minute left.

**Mr. Brian Pollard:** Homes also have the ability to reach out to their partners to learn best practices on acquiring and retaining staff.

In terms of the broader supply question and how we're addressing that, I think the minister mentioned yesterday that we have, for example, a pool of PSWs that we know just aren't converting into the health workforce.

Part of what I've said before is part of the strategy to make sure that they convert, which is to say that when you graduate from PSW school, when you graduate from RPN school or RN school, we appreciate that long-term care may seem daunting, but let's see if we can help with some of the training and expertise that's required.

We're also looking at whether placements in long-term care can happen later in a person's curriculum. We've been told, and we hear, that placements in long-term care usually happen very early—

**The Chair (Mr. Peter Tabuns):** I'm sorry to say you're out of time.

**Mr. Brian Pollard:** Okay.

**The Chair (Mr. Peter Tabuns):** Thank you for your line of questioning.

We go to the opposition. Ms. Armstrong.

**Ms. Teresa J. Armstrong:** Chair, I'm just requesting a five-minute break before we start the next round of questions, please.

**The Chair (Mr. Peter Tabuns):** Unanimous consent is required. Does the committee agree to a five-minute break? We're all agreed? We will recess for five minutes.

*The committee recessed from 1703 to 1709.*

**The Chair (Mr. Peter Tabuns):** We're back in session. With that, Ms. Armstrong, you have the floor.

**Ms. Teresa J. Armstrong:** Thank you so much, Chair.

Thank you for being here today to answer our questions on the estimates.

I'd like to ask: What does the transfer payment agreement require for matching from the provincial government for mental health, home care and opioids?

**Ms. Helen Angus:** That would actually be a federal-provincial agreement between Ontario and the federal government around matching.

Minister, if it's okay, we might ask Patrick to come up. Patrick actually has the federal-provincial relationship and the staff that supports our intergovernmental relationship there. So why don't you do your best.

**Mr. Patrick Dicerni:** I'm Patrick Dicerni, assistant deputy minister of administrative health and long-term care, policy and strategy. Thank you for the question.

With respect to the bilateral agreements that have been reached with the federal government, both in home care and mental health and the one-time emergency fund that's been established with respect to opioid crisis response, let me first start with the home care and mental health agreements. Although there is a 10-year horizon to that agreement, what we have in place with the federal government right now is a five-year agreement, and that's standard for other provinces as well. It is not a year-over-year matching requirement. There is a matching requirement over the lifespan of that agreement. Those are the obligations on the provinces and territories with respect to the matching, if you will.

With respect to the one-time opioid emergency fund, the Ontario provincial share on that is in the range of $51 million. The treatment there is a little bit different than the previous bilateral agreement that I spoke about. It is retroactive in terms of the matching back to 2016-17; it's thereabouts when the face of the crisis really started becoming apparent in our data.

With respect to the horizon for providing that match, that is a 2017 through 2022-23 matching requirement. Through the course of the normal business planning cycles of government and the investments that we've spoken about already to some degree with respect to where we're spending mental health money, it is anticipated that the provincial government will be more than able to achieve that matching over the horizon of the agreement.

**Ms. Teresa J. Armstrong:** Okay, thank you. As asked yesterday, can you please specify how the number of savings, such as the $350 million in health care restructuring, was calculated? And if this information is not currently available, then how much of the administrative spending occurred in 2018-19 of each of the 14 LHINs and the six agencies that are scheduled to form the new agency?

**Ms. Helen Angus:** It's Helen Angus, deputy minister.

We're working with the new board of Ontario Health as they look at all of the financial profiles of the founding organizations that are going to be rolled into Ontario Health once the legislation is proclaimed, and then decisions are made to move the assets of the agency.

We're actually undertaking an asset review at the moment. We're about to embark on looking at things like leases. There are 158 of them, for example. We're looking at back-office functions and the opportunity to consolidate things like payroll systems, human resource functions, communications functions and other things.

I can say that, I think as we mentioned yesterday, the board of Ontario Health has met seven times. They've started the work, and I can tell you that they're on track to achieve the savings target that was identified this year.

**Ms. Teresa J. Armstrong:** Okay. Specifically, can I ask you how the $350 million was actually calculated, and then also how much administrative was spending during 2018 of each of the 14 LHINs and the six agencies that are supposed to be scheduled to be a new agency? Do we have it calculated for the $350 million—how you came about that figure and what administrative spending occurred during that time to change the structure of the LHINs and the six new agencies?

**Ms. Melanie Fraser:** I'm Melanie Fraser, associate deputy minister. I'm happy to try to answer as much of the question as I can.

We had the 20 agencies or organizations identified to go into Ontario Health. What we first did was remove from their global budgets anything that had to do with patient-facing or patient-supporting care. What remained in each of the organizations' budgets was then their administrative spend.

From that, we looked at prior-year spending. A number of these organizations did have underspending in 2018-19, and we looked at what could be a reasonable reduction in their administrative spend, based on some of the vacancies that they were holding, the number of leases that they had, the number of consulting contracts, travel etc. I would say we didn't do finite math on that, but rather what we determined was that very conservatively, we could probably find 15% in savings on the administrative budgets only. Over a two-year period, as they were moved in and consolidated into Ontario Health and the duplication was moved, that could increase to approximately 20%, so that's where you get the $256 million growing to $350 million.

As the deputy said, now, with the new board in place and having had seven meetings already, they are doing the detailed dive on those budgets and have very easily been able to identify where in those administrative budgets they could find those savings. As I said yesterday, I believe all of our assumptions are proving to be true.

**Ms. Teresa J. Armstrong:** Do you know what specific actions will happen to achieve those savings, though?

**Ms. Melanie Fraser:** I would say that the specific actions will be the responsibility of the board. The board will make those decisions as they work with the organizations. But yes, specifically, there were a number of vacancies in these organizations; we'll be looking at whether those vacancies which have been in place for some time are still needed.

As the deputy mentioned, there are 158 different properties. We know that one agency doesn't need 158 locations across the province and that there are opportunities not only to consolidate locations, but to find better-priced locations. We have an asset review where we've brought in some experts to help us value the assets in those organizations and look at everything: 20 payroll systems, 20 financial systems—there's a clear opportunity here to remove some of this duplication and terminate those contracts. There's—

**Ms. Teresa J. Armstrong:** Okay. Sorry to interrupt you; I have to get through my questions.

**Ms. Melanie Fraser:** No, that's fine.

**Ms. Teresa J. Armstrong:** Some of those metrics you've talked about before.

The estimates show that there already have been efficiencies identified in 2019-20. Can the government show how they have reinvested these savings into front-line care, as they committed to do?

**Ms. Helen Angus:** It's Helen Angus again.

Some of those savings were assumed at the time of budget. They form part of the government's investment in the health care system this year.

I can tell you, as well, that as the board of Ontario Health is doing its work on efficiencies, they're finding opportunities to invest in additional volume. One of the things that Ontario Health has done already is looking at administrative efficiencies. They have achieved the target that we asked them to, and they're suggesting that they put some additional savings into more PET volumes this year. This is exactly what we wanted them to do, to look at pinch points in the system where there were opportunities to put more money into front-line care, and they're doing that. I expect that that work will continue—whether it's money that gets expressed through the budget or whether in-year they're able to actually move money in order to provide more and better care for Ontario patients.

**Ms. Teresa J. Armstrong:** So the PET investment is one example that you're referring to?

**Ms. Helen Angus:** Yes, it is.

**Ms. Teresa J. Armstrong:** Are there other examples of what has been reinvested into front-line care?

**Ms. Helen Angus:** They're just beginning their work now, but that has come forward to us, hot off the press, in the last week. I think you will see other examples as Ontario Health starts to do its work about how the money actually is moving into what we would call "volume." Additional services, particularly for those like cancer surgeries, like breast screening, like PET scanners, are volume-funded.

**Ms. Teresa J. Armstrong:** I appreciate that we have a time here, so I anticipate that that we could get that information reported back to the committee. We'll continue to inquire through the Clerk to make sure that we get that information.

I want to talk a little bit about home care right now. The government talked about building beds. Can you clarify whether the 7,232 long-term-care beds that the government allocated since 2018—if any of those allocations were previously allocated by the Liberal government? And, if so, what's that number?

**Ms. Melanie Fraser:** Sorry, I think we're going to ask our ADM of long-term care to come to speak to the details of these numbers. He'll have them off the top of his head. We'll have to dig through binders, so this will make it easier for all of us.

**1720**

**Ms. Teresa J. Armstrong:** Just to clarify the question: You guys have announced 7,232 since October 2018. Of that number, which ones were Liberal allocations already?

**Mr. Brian Pollard:** Good afternoon again. Brian Pollard, assistant deputy minister for the long-term-care homes division.

MPP, I'd have to check. What we did is we followed the policy principles that I talked about in my earlier presentation. We were really looking for projects that would help us with hallway health care and solve the ALC issue, the crisis issue. I'd have to get back to you to see what they—

**Ms. Teresa J. Armstrong:** Okay, so you don't know if the number that the Liberals had already announced is included in this and what portion that is. Would that be fair to say?

**Mr. Brian Pollard:** Yes, I don't know the exact, so I wouldn't want to lead you—

**Ms. Teresa J. Armstrong:** So you'll bring that back to us?

**Mr. Brian Pollard:** We can look into it.

**Ms. Teresa J. Armstrong:** Okay. My next question is, what steps has the government taken to ensure that the 15,000 long-term-care beds are created within the five-year time frame that has been announced? And of those beds, can you tell me how many are public and how many are private planning, when the construction would start and how you determined where to build those beds?

**Hon. Christine Elliott:** I can tell you that that was one of our primary commitments to the people of Ontario during the last election, so it was one of the chief jobs that I took on as Minister of Health and Long-Term Care. We started work on the list of the new long-term-care beds and we're also working on the redevelopment of 15,000 long-term-care beds.

As you will know, often, when you are upgrading some of the B- or C-level beds in some of the smaller communities, because they were not built to modern design standards—you may have four bedrooms—you end up having to build new in addition to the redevelopment that you're working on.

That has been one of my primary commitments since becoming minister, but I will ask Mr. Pollard for further information.

**Ms. Teresa J. Armstrong:** I really appreciate what you said, Minister, but because of my timing, I have to be direct. I just need to know what steps are being taken to ensure that those 15,000 long-term-care beds are built within that five-year commitment.

**Mr. Brian Pollard:** Good afternoon, and thank you for the question, MPP.

In terms of steps taken—I should say that MPP Gates asked me to speak a little bit slower, so I'm going to try to do that.

**Mr. Wayne Gates:** Very politely, though; very politely.

**Mr. Brian Pollard:** In terms of steps taken, the first step is really making sure that we have an allocation that meets the government's policy objectives. Those objectives, again, were to solve hallway health care as defined by looking at areas that had high ALC rates and I'd also say probably have persistent high ALC rates; also high crisis rates, and those are people usually coming in from the community right into long-term care; and areas that are seeing significant population growth above age 75. I think one of your questions was how do we decide where to put beds, and that's really the thinking that goes behind it.

Once we've done the allocation, which is saying we've received some information from the operator and you're in an area where we have some mutual interests in seeing capacity built, then the process starts to have more in-depth due diligence—get more information from the operator. That's another area where we have taken some concrete steps to shorten the timeline.

We are going to be modernizing how we look at public consultations. That will help us shorten the timeline between allocation and approval. Then once the approvals are given, it's over to the operator to work with the local—

**Ms. Teresa J. Armstrong:** I appreciate your response. You kind of gave me the metrics at the beginning, so I appreciate that.

You're committed to building those 15,000 beds in five years. Has the government completed a risk assessment of whether long-term-care residents and staff will be at risk in staffing levels? Because if they don't increase—there are more beds created. Have you looked at that assessment and what that's going to take to make sure there are properly staffed new beds?

**Mr. Brian Pollard:** We certainly know, as I mentioned earlier, that we will need more staff. I don't know if I'd

call it a risk assessment as opposed to maybe a supply assessment. We know that we will need more help from human resources.

**Ms. Teresa J. Armstrong:** You may be aware of the two reports that came out recently called Situation Critical from the Ontario Health Coalition and Breaking Point: Violence Against Long-Term Care Staff that was just released by CUPE in 2019—a very serious issue. I would just urge the government to take that undertaking very seriously because there is neglect and violence, and we want to make sure both residents and staff, of course, are working in a healthy and safe environment.

My next question is: Can the government please clarify if "long-term-care spaces" has a different meaning than "long-term-care beds?"

**Hon. Christine Elliott:** Well, I would say that we are taking a look at what other types of spaces could be, instead of just new builds of long-term-care beds or redevelopment of existing long-term-care homes. We are looking at some other situations. There may be some spaces that are not used, for example, in retirement homes that may be able to bring someone who is an alternate-level-of-care patient from a hospital to a retirement home with the home care needs, with the provisions and services that they have, which will create a space. But that's not included in the new-long-term-care-bed component.

**Ms. Teresa J. Armstrong:** So your 15,000 beds that you've committed to are actual new constructions of beds, and these spaces that you've described will not be part of that 15,000 new beds?

**Hon. Christine Elliott:** That's correct.

**Ms. Teresa J. Armstrong:** Okay. So, from the 15,000 beds—and I'm sorry I'm hurrying you a little bit—that are created, can you tell me what you've allocated for private and public when you're constructing these new beds? Is there a plan around keeping them public and not-for-profit, or is it just first-come, first-served? What kind of numbers do you have for us on that prediction?

**Mr. Brian Pollard:** I would answer that by saying that we allocate where the need is. We are agnostic in terms of the private versus the not-for-profit, and we're really committed to trying to get the beds online as quickly as possible. That having been said, I don't have the exact percentages in front of me, but we have all business ownership types who have been allocated projects.

**Ms. Teresa J. Armstrong:** I have a specific case I wanted to talk about with regard to Sault Ste. Marie. Cedarwood Lodge in Sault Ste. Marie—family members of residents are under the impression that Cedarwood is an interim-care treatment occupancy facility where patients from the Sault Area Hospital have been transferred temporarily until a long-term-care, permanent home becomes available.

The northeasthealthline.ca classifies Cedarwood Lodge as a long-term-care home. Can the ministry staff here today share clearly the current status of Cedarwood Lodge in Sault Ste. Marie?

**Mr. Brian Pollard:** It is a long-term-care home, and because it's a long-term-care home, it falls under all of the same regulations and funding regime as any other long-term-care home in the province. There are interim beds in the home, but I'd make a distinction between that and whether it is a long-term-care home. It is actually a long-term-care home.

**The Chair (Mr. Peter Tabuns):** You have one minute left.

**Ms. Teresa J. Armstrong:** Okay. My last question, then, would be, if the government can look at the Time to Care bill that was presented—have you assessed that at all in calculating, perhaps, the staffing levels, when it comes to building the new beds?

**Mr. Brian Pollard:** Yes, in terms of the Time to Care bill, the way that we approach staffing within long-term-care homes is that all homes are required to have an organized staffing plan that matches the needs of the residents in the home. As you can imagine, the needs vary depending on which home you're in, which is why we have flexibility built into our regulation in terms of the organized plan that homes can deploy—

**The Chair (Mr. Peter Tabuns):** With that, I'm sorry to say, your time is up.

We go to the government: Mr. Pettapiece.

**Mr. Randy Pettapiece:** Good afternoon. Thanks for coming out today. It's always nice to listen to commentary on our health system.

The question I'm going to ask you is something that's dear to my heart, because it has the term "golden years" in it. I don't know what that means; perhaps somebody could explain that to me.

**1730**

But anyway, it's no secret that baby boomers are hitting their golden years, and many are needing support to continue living in their own homes. These home and community care providers are critical to help provide a smooth transition for people who need support after returning from a stay in hospital, rehabilitation or another health care setting. They are a key player in our efforts to help end hallway health care.

Minister, can you please provide an update to the committee on our government's support and work in this sector, and how home care will remain an important part of our health system going forward?

**Hon. Christine Elliott:** Yes, thank you very much for the question.

Home care services are an extremely important part of our health care system, allow more people to live independently in their homes for as long as possible and reduce the use of more costly health care services, such as hospitals and long-term care.

The government is implementing a long-term transformational strategy to modernize our system and redirect money to front-line services, where it is still greatly needed, providing better, faster and more connected care to patients and families. That is something that I've certainly heard a lot about for a number of years, including my time as Ontario's Patient Ombudsman—that people are not feeling connected to care. Home care is an important part of bringing that together.

Home care services do include personal support services and nursing, and can be provided to assist after discharging people from hospital, to people who have long-term needs or to people who choose to remain at home for end-of-life care—that is, the hospice services that can be provided by long-term care are growing in number and are being more and more used by people. Although we are developing more hospice services, which is great, not every community has a hospice, and so home care services are providing that vital service as well.

The ministry is planning to invest an additional $124 million to expand home care services in 2019-20. Ontario health teams will be a new way of organizing and delivering services in local communities. Local health care providers, such as doctors, nurses, hospitals, home care providers and long-term-care providers, would work as one connected team no matter where they provide care. The ministry is committed to working with patients, families and providers to ensure a seamless transition of services for Ontarians receiving home and community care. We do recognize the important role that home care and community services play in our effort to end hallway health care in Ontario.

Just to say one other point with respect to the local Ontario health care teams: We are very pleased that we've had the first deadline pass for submission of applications to become a local Ontario community health care team. We've received over 150 applications, which is very, very encouraging, from all parts of the province. We look forward to reviewing those applications to determine their readiness to actually step in and provide care. We won't be divesting care from the LHINs directly to those local health care teams until we're sure that the patient experience will be complete and full. We don't want to have any concerns with respect to that. We want to make sure that when the local health teams are ready to go, they can step right in and provide that seamless care.

Now I will ask the deputy to provide some additional information on how we will provide patients and families with more home care services and programs.

**Ms. Helen Angus:** Thank you, Minister. It's pretty clear that home care plays an important role not only in ending hallway health care, but obviously in the lives of families. I have a mother on home care and I understand the role that it plays. It allows her to stay home with support in her own home, and it really makes a difference for all of us. So I have a personal interest in this.

I'm pleased to say that the ministry is investing another $124 million to expand front-line home care delivery in order to provide patients with more access to care. When we think about what that buys us to makes it concrete, that would provide an estimated 1.8 million more hours of personal support services, about half a million more nursing visits and over 100,000 more therapy visits. It's also community care. We're also investing $20 million in community services that also make a difference in the lives of the people of Ontario.

But as the minister mentioned, it isn't just about investments but how these connect to other services within the community and how we really make sure that they're a part of the team that's centred around patients—so really, our efforts to make sure that all the dollars we can get go into the front line and provide the best value for the people of Ontario.

We do want more care delivered outside of hospitals. I think Mel is going to talk a little bit about some of the examples of where we're seeing the real potential of connecting care between the hospital and the home care providers and the other providers in the community. We've got a track record of doing some pretty good work in this area, to the benefit of patients. Ontario health teams are going to make that a regular feature of the health care system.

We know that there are opportunities here to reduce duplication. The repetition for patients trying to tell their stories over and over again, the gaps that happen between providers, I think, are the things that the Ontario health teams are going to take straight aim at.

All of that costs time and money. I think there are opportunities for us to repurpose the dollars into the direct care that people need and deserve. We have an opportunity and a motivation—for some of us, personal—to improve home care and community delivery.

I'll ask Mel to give a little more of a technical view about what we're doing. But obviously, it's of great interest to the people of the province, how we're doing this.

**Ms. Melanie Fraser:** Great. Again, Melanie Fraser, associate deputy minister.

I couldn't agree more with the deputy about what a critical component of our overall health care system that home care and community services are becoming. When we think about home care and community services, it's nursing, it's personal support, but it's also homemaking, it's therapies and it's other professional services that might be provided either in the home, might be provided in a school or in a community setting. It's funny that you referenced the golden years—but I think more and more we think about home care becoming a greater part of the patient care journey for all ages of patients and their families.

If I'm allowed to get personal, I had a mother who was in a hospital for a year after a massive stroke in her forties. Home care allowed her to come home and live with us for 20 years before she had to transition back into a long-term-care home. It is really a vital part of the patient experience and allowing people to live their full lives with the medical care they need but in the setting that they choose. As you can see, the commitment here goes to our core.

Of course, this also involves home care for people at the end of their lives. It's such a critical part of allowing people to make choices in where they receive care at the end of their life, whether that be in their home or in a hospice. Our strategy obviously wants to support more and more of that and patient choice in that option.

I think mentioned earlier today—and this figure, actually, I find astounding—that over 700,000 people in the province receive home care, so 100,000 visits a day.

That's a figure that's going to grow and grow—again, another compelling stat that says that we need to make sure that this is well integrated into the full health care system and that we make the most of each of those visits and make sure that they're well integrated with the care pathway.

Of Ontarians aged 75 to 84—I think those are maybe the golden years—

**Mr. Randy Pettapiece:** I'm not there yet.

**Ms. Melanie Fraser:** Not there yet—I wasn't saying you were—some 22% of those people are receiving home care, so one in five. When you're over age 90, that's almost half who are receiving home care. So it's a big part of the golden years, of later life, as well.

These home care services are then complemented by community services: Meals on Wheels services, adult day programs, things that help with isolation, with basically assisting people in living their full lives at home as they age or as they deal with acquired brain injuries or whatever that might be.

**1740**

As the deputy mentioned, our challenge is to transform the system in order to make sure that we're integrating home care into health care delivery for the sustainability of the health care system. In the current model today, we have LHINs—local health integration networks—who become or who are kind of the primary overseers of the current home care model. I think what we've realized is that, while they do a good job, there do tend to be disconnections in the number of transitions. There are a lot of assessments that patients have to go through, multiple visits and multiple hand-offs, which obviously just create the opportunity for things not to go smoothly.

As we move forward with Ontario health teams, the idea is to break down some of the silos and to increase the flexibility, all for the purpose of integrating the care around the patients. I think we've talked a lot about Ontario health teams, but again, it is this team of health service providers that will create a continuum around patients. Imagine your family care doctor being connected with your home care worker, being connected to the hospital that you frequent, being connected to the therapist who does your physio, and them being able to share a record about your health and them being able to work as a team to combine care for you.

We have many examples in the province of where this is happening. The minister mentioned Southlake@Home. That's a fantastic example where not only is it working really well, but it's reducing the amount of time spent in hospital. Patients are having better experiences. The number of return visits, readmissions to the ER, is down by 15%. Emergency department visits within 30 days are reduced by 15%. Readmissions overall are down by 20%.

That's an experience that we also see with our bundled care pathways, which I talked a little bit about yesterday—again, a similar concept to Southlake@Home, where they connect the hospital to the home care and make sure that there's a good plan for the patient that takes them and carries them through that setting. It shouldn't matter which institution or what bricks and mortar you sit in; you're still getting care. The bundled payments kind of do the same thing, or the bundled care does the same thing.

If you're having hip surgery or knee surgery—we've got great examples of lung cancer patients receiving this type of care where they're actually meeting their home care providers in the hospital. Before they're released from hospital, they know where they're going to get care, they know who to call 24/7, and that helps them get better care. They feel comforted. If they've got very complex conditions, there's a lot less anxiety around their care and their health, and it really does improve their health outcomes as well as producing savings for the system. So those are some fantastic examples there.

I'll just tell you about a few other things that we have under way. Apart from Ontario health teams, which we've talked a lot about, I think one of the other things that has come up a little bit today has been the shortage of personal support workers across the province and how it's challenging to provide patients with the necessary supports that they need. We are working as a ministry on implementing a strategy to really augment and build a safe and highly competent PSW workforce throughout the province. We need to ensure that we have a PSW workforce everywhere that we need it, so our strategy will focus not only on recruitment but also on retention and training initiatives.

I think one of the flow-on benefits that we've seen from integrated care teams already is that the quality of the experience of the PSWs who work on those teams and their commitment to those teams and to those workplaces has been exponential. I think if you talk to the folks, they feel like they're part of the team that is curing cancer, they feel like they're part of the team that is responsible for somebody having a new hip, a new knee. So we do hope that one of the added benefits of moving forward with more and more of these integrated care teams is also providing that highly meaningful career pathway to the PSWs and the nurses and all of the health service providers who work in the system.

We also have been doing some work with our PSWs and our partners on improved scheduling. I think we all recognize that there can be a lot of demand in the early hours of the day and in the late hours of day, creating a bit of a gap in between, a lot of travel for PSWs and a lot of downtime. We really want to look at opportunities to increase the stability of their employment and make their days more normal and really maximize the time that they have.

Another interesting thing that we're working on is our community paramedicine initiative. I think this is a really innovative initiative. We're providing $6 million in funding to support this program across the province this year, taking paramedics who are already in the community and providing visits to seniors and high-needs patients and having them do some assessments and referrals right from the home. Our paramedics will be able to take highly complex patients with extreme mental health needs directly to centres that can support them and provide education to caregivers and to patients about chronic disease management with things like COPD and things like that.

We're also adding $33.6 million to add 193 new hospice beds. Again, as I spoke about earlier, it's such an important capacity to add to the system. When those beds open, we have additional operating funding for more nursing, more personal support and other support services for those operations—again, another critical part of supporting the population.

We're also, then, expanding caregiver support. Again, all of us have this personal experience of being caregivers. They're critical to the sustainability of the health care system as well. It takes a village to support our families and especially to support them when they're sick, and so it's important that we support the caregivers and ensure that they have the information and the supports that they need. There are a lot of supports out there. There are great organizations like the Ontario Caregiver Organization, which is arm's-length to us, but it coordinates giving access and information and supports to caregivers of all ages and needs. I think it's a really important part of the system.

This year, there will be 16 new training and education programs for caregivers. That will include Franco-Ontarians. We'll be targeting different cultures and different groups, recognizing the diversity of the province, including LGBTQ communities, Indigenous people and especially caregivers of frail seniors, which is a growing population. As I mentioned, some of these programs will help caregivers find the information and the resources they need not only to take care of their loved ones but to take care of themselves. It's really important that they focus on personal care as well.

We're also expanding a patient choice program. It's called Family-Managed Home Care. Basically, what this does is provide funding directly to a family so that they can hire the care providers and purchase their own service.

**The Chair (Mr. Peter Tabuns):** You have one minute left.

**Ms. Melanie Fraser:** Thank you.

That's one thing that we've heard from families—that this can make a significant improvement to their day-to-day lives if they can build a stable care team around them of trusted providers who know them and know their needs and know what to do when something changes.

We heard that from a family of a young person who was non-verbal. It was really important that the caregivers were consistent and had a deep understanding of the child. Programs like this will help to make sure that those supports are in place.

Maybe I'll just wrap up on that and say that it's a hugely important area of focus for the ministry that will be integrated into all of our other modernization work. We're making, I think, great investments and great strides here, but there's more work to do.

**Interjection:** Great job.

**The Chair (Mr. Peter Tabuns):** And good in terms of the clock, as well. Thank you.

To the opposition: Ms. Armstrong.

**Ms. Teresa J. Armstrong:** Just to jump off of the home care piece: The budget shows an increase of $267 million in home care and community care for 2019-20. The federal government provided $251 million in home and community care funding for 2019-20. Can the government confirm that it is only spending an additional $16 million of provincial health dollars in 2019-20?

**1750**

**Ms. Melanie Fraser:** Melanie Fraser. You're stumping me on that one, so I think this might be a question that we need to take back.

**Ms. Teresa J. Armstrong:** Okay.

**Ms. Melanie Fraser:** Yes. We'll just look into it.

**Ms. Teresa J. Armstrong:** Thank you. I'm going to pass it over to Judith.

**Ms. Judith Monteith-Farrell:** Thank you for the opportunity to ask these questions. I'm going to go to the area of public health. The government announced changes to public health, as the minister stated in her speech yesterday. These changes are expected to be fully implemented in the next fiscal year. Can the government confirm whether the proposed changes to the cost-sharing funding model for public health will be 70% provincial to 30% for small and rural public health entities, 60%-40% for larger public health entities and 50%-50% for Toronto?

**Hon. Christine Elliott:** We anticipate that with the additional year that's been given to the municipalities in their public health units, they will be able to find those savings. There is a difference depending on the municipality and how it will be impacted by these changes, whether it will be 70%-30%, 60%-40% or 50%-50%.

**Ms. Judith Monteith-Farrell:** And have they been informed on where they fall—

**Hon. Christine Elliott:** Yes. Oh, yes, they have.

**Ms. Judith Monteith-Farrell:** All right.

**Ms. Helen Angus:** We're actively working with the municipalities. We have a process of engaging municipalities to help them and us plan for what's going to happen next year.

**Ms. Judith Monteith-Farrell:** Okay. Next, what percentage of provincial funding does the government anticipate providing for land ambulance services in 2019-20?

**Ms. Helen Angus:** I'm going to have to look at my binder. Maybe we'll get Alison in here.

**Hon. Christine Elliott:** Stable funding that's consistent with the existing year—I'll have to ask for the actual number. Perhaps someone from the table can confirm that.

**Ms. Helen Angus:** Yes. If we can get Alison up here.

**Ms. Judith Monteith-Farrell:** And just secondary to that, can you confirm that it's the same level as 2017?

**Hon. Christine Elliott:** Yes. My understanding is that it is, but we'll ask Alison to please come forward. She is the expert in this area. Thank you.

**Ms. Helen Angus:** Alison, introduce yourself.

**Ms. Alison Blair:** Yes. Hi, there. I'm Alison Blair. I'm the acting assistant deputy minister for the hospitals and emergency services division.

**Ms. Judith Monteith-Farrell:** Great. Thank you.

**Ms. Alison Blair:** In the estimates briefing binder that we have here, what it shows is that we are providing stable

funding for the Land Ambulance Services Grant. That means we're providing the same amount to municipalities in 2019-20 as we did in 2018-19. The reference to 2017—the municipalities, when they submit their budget for Land Ambulance Services Grants, base it on the previous year's council-approved budget. So that's the reference to 2017, but we are providing the same stable funding.

Now, after the announcement last week, what we're doing is, we're working with municipalities and within the government to determine exactly the impact of funding on that, but the estimates briefing shows exactly the same funding as 2018-19.

**Ms. Judith Monteith-Farrell:** All right. Could we have that in writing, in a report, or is it in—

**Ms. Alison Blair:** Yes.

**Ms. Judith Monteith-Farrell:** Okay. And will the new public health regional entities support both public health services and emergency services?

**Ms. Helen Angus:** I don't believe that's the intention, actually. I think the intention is to create regional capacity for public health that is really focused on population health and the things that public health does so well. Although they're both connected by virtue of affecting municipalities, we're actually treating those in two separate conversations with municipalities.

**Ms. Alison Blair:** Yes.

**Ms. Judith Monteith-Farrell:** Okay. Thank you. What were the provincial funding contribution levels for all public health units in 2018-19?

**Ms. Helen Angus:** It did vary. Maybe we can ask Peter to come up, but the public health funding—I remember the chart. I don't have it in my head, but it did vary, I would say, quite substantially depending on the municipality, and it's varied considerably over time as well. If we actually look back over time, the relative contribution of the municipalities and the province has changed and there have been different arrangements over a period of decades.

I don't know if we have that here with us, but it isn't a uniform number across all municipalities, and it really largely depends on how the public health units allocate and spend their money.

**Ms. Judith Monteith-Farrell:** So could we get that researched and reported back to the committee?

**Ms. Helen Angus:** We can definitely see what we've got.

**Ms. Judith Monteith-Farrell:** And the same for land ambulances: What were the funding levels for 2018-19?

**Ms. Melanie Fraser:** That wouldn't be broken down in the estimates, but we can look into that.

**Ms. Judith Monteith-Farrell:** All right. Thank you.

**The Chair (Mr. Peter Tabuns):** Ms. Armstrong.

**Ms. Teresa J. Armstrong:** Just to wrap up, I've got a couple of questions on the home care file. Can the government explain and provide a reason for cutting $12 million from community support services in the budget line in vote 1411-1?

Maybe while you're looking up, I can ask another—got it?

**Mr. Peter Kaftarian:** Peter Kaftarian, chief administrative officer. Do you have a page reference?

**Ms. Teresa J. Armstrong:** I don't have a page reference. I just have the vote number 1411-1. I can leave that with you for a moment, and then I have another question on home care. Of the $6.5 billion spent on community programs in 2019-20, I was wondering if you could give us a breakdown on how much is spent on home care, on community support, how much is directed to LHINs and how much is transferred from the LHINs to the home care providers. I'd appreciate a breakdown. I don't know if you have that here—yes?

**Ms. Helen Angus:** I don't think we have it by each LHIN.

**Ms. Melanie Fraser:** It's Melanie Fraser. The $124-million increase for home care and the $20-million increase for community supports gets flowed to the LHINs and then it gets flowed out to the service providers. Those are monies that go to direct services, if that's the question. It doesn't remain in the LHINs.

**Ms. Teresa J. Armstrong:** Okay. But there's $6.5 billion spent on community programs in 2019-20. Home care—you don't have an amount for that?

**Ms. Melanie Fraser:** The total spend for home care.

**Ms. Teresa J. Armstrong:** Yes, and then community support—how much goes to the LHINs, and then how much is transferred from the LHINs to home care providers? If you don't have that now, can I ask for it to be reported back to the committee and we'll follow up with the Clerk for that information on both of those questions?

**Ms. Melanie Fraser:** I'm able to answer the home care question. The total funding for home care is $3.1 billion in 2019-20.

**Ms. Teresa J. Armstrong:** Okay. And the next one would be community support.

**Ms. Melanie Fraser:** Just one moment.

**Ms. Teresa J. Armstrong:** I'm sorry. It's Peter, is it?

**Mr. Peter Kaftarian:** Yes.

**Ms. Teresa J. Armstrong:** Do you happen to have the vote for 1411-1? It's on page 136.

**Mr. Peter Kaftarian:** Yes. Can you please clarify the specific number you were asking about again?

**Ms. Teresa J. Armstrong:** Yes. Can the government please provide reasoning for cutting $12 million from the community support services budget line in vote 1411-1?

**Mr. Peter Kaftarian:** Just one second. Thank you for the clarity.

**The Chair (Mr. Peter Tabuns):** And just to let you know, you have one minute left.

**Ms. Teresa J. Armstrong:** So, just in the spirit of timing and understanding how complicated these questions can get, I would ask if you could please find the answers and report them back to the committee, and we'll follow up with the Clerk for that information. Thank you so much.

**Ms. Melanie Fraser:** Thank you.

**The Chair (Mr. Peter Tabuns):** Thank you, and with that we'll adjourn until 9 a.m. Tuesday, September 10.

*The committee adjourned at 1800.*

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